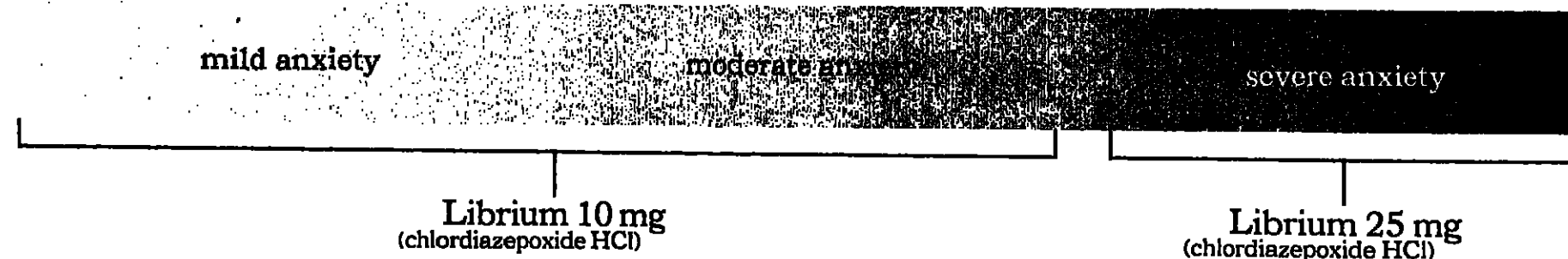


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Med Trib

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Vol. 16, No. 3

world news of medicine and its practice — fast, accurate, complete

and Medical News

Wednesday, January 23, 1974

All Specialty Boards Committed to Recertification



Studying together in Chicago for recertification examinations given by the American Board of Internal Medicine, Drs. Clifford J. Pilz, Armand Littman,

Jay Colbert, and W. Robert Meadows quiz one another in the first voluntary recertification since the medical profession was organized into specialties.

Medical Tribune Report

All 22 specialty boards are now committed to the principle of recertification, a survey by MEDICAL TRIBUNE shows. At least two have adopted plans that eventually will require renewal of certificates.

The first to adopt mandatory recertification was the American Board of Family Practice. The first group of diplomates, certified in 1970, must undergo re-examination in October, 1976.

The procedure will consist of evidence of continuing education (300 hours over the six-year period), an appraisal of the professional character of the candidate, a cognitive examination, and a review of office records.

The 4,000 diplomates of internal medicine who on October 26 took the first voluntary recertification since the medical profession was organized into specialties almost 60 years ago, will receive their confidential scores between February 1 and 15, according to Dr. Palmer H. Fitcher of Philadelphia, executive director of the American Board of Internal Medicine.

"We estimated that 16,000 certified internists were eligible, so that the

Continued on page 13

Intractable Enteric Bacillus Menaces U.S. Burn Centers

Medical Tribune World Service

BUENOS AIRES—Providencia stuartii, a rampaging, enteric bacterium, apparently resistant to all known antibiotic agents, may be the next infective agent to sweep through burn centers in the United States. It has invaded burn wounds, caused pneumonia, and often, fatal septicemia.

This frightening warning was voiced here by a group of investigators from one of the United States' leading burn treatment and research centers. Drs. R. B. Lindberg, A. D. Mason, Jr., and B. A. Pruitt, Jr., of the U. S. Army Institute of Surgical Research at Fort Sam Houston, Texas, reported on the uncontrollable pathogen at the 4th International Congress on Burn Injuries, here.

Since 1969, Dr. Lindberg said, there has been a marked rise in bacteremia, sepsis, wound colonization and invasion, and pneumonia caused by Providencia stuartii. And there has been a concurrent increase in mortality

Continued on page 15

Misdiagnoses Snag Sicklemia Screening Plans

Medical Tribune Report

SANTA MONICA, CALIF.—Community screening programs for sickle cell anemia, as they are now set up, may be doing more harm than good, according to Dr. James E. Bowman, director of the Comprehensive Sickle Cell Center at the University of Chicago.

"In Chicago we spend most of our time trying to straighten out people who have been misdiagnosed by community screening programs," the black physician told a conference on sickle cell diseases sponsored by the Intra-Science Research Foundation here.

Misdiagnoses of the sickle cell trait—that is, the possession of a single gene for sickle cell hemoglobin in otherwise normal individuals—have led to unnecessary doubts about parentage, difficulties in getting jobs, and, in some cases, computer readouts that lump the sickle cell trait with the disease itself, he said.

Continued on page 16

making rounds at press time

STEEL PLANT RISK—A study to be completed later this year of the details of the deaths of 361 employees of a Md. steel plant is showing 47% more than expected deaths from stroke, 43%

more from cancer (lung, leukemia, and bladder cancer leading), and higher respiratory disease deaths, according to Dr. Edward P. Radford, Prof. of Environmental Med. at Johns Hopkins School of Hygiene and Public Health. Mortality rate studies and specific occupational breakdowns are pending.

55 MPH—After a year of trying it out, the 55 mph speed limit looks like the safe thing to do. Dr. Alexander Hering, Assistant Director of the American College of Surgeons Trauma Division, said in reference to the bill signed by the President Jan. 4. "Not enough time has elapsed to get the full statistics but

we know there have been fewer deaths since people started slowing down." **MEDICAID**—A Government Accounting Office study of Medicaid in Ill. is expected to be sent to the Senate Finance Committee next month. Report grows out of accounts of overcharging by factoring firms collecting on behalf of MDs.

Inoperable Lung Cancer Eludes VA Therapy

Medical Tribune Report

CHICAGO—After 16 years and 13 sequential, controlled studies with nearly 2,000 male patients in 26 Veterans Administration hospitals, the goal of extending life in patients with localized but inoperable or nonresectable lung cancer has proved "elusive" and the odds for survival are "grim."

This assessment was presented to the Radiological Society of North America by the chairman of the Veterans Administration Lung Cancer Group (VALG), Dr. Julius Wolf, who is also chief of staff at the VA hospital in the Bronx, N. Y.

Only 48 (3.8 per cent) of 1,279 such patients in the first eight studies lived two years after beginning therapy, Dr. Wolf said.

In the 13 studies, radiation therapy was randomized with an inert compound and with alkylating agents, androgenic agents, and the nitro-soureas. In the first seven studies, an inert compound was used as a therapeutic control. In subsequent studies, radiation and cytoxin were used as the "reference regimen."

Small Beneficial Effect

Dr. Wolf reported that radiation therapy (notably supervoltage), alkylating agents (principally cytoxin and nitrogen mustard), and the nitro-soureas (particularly CCNU and BCNU) have "a significant but distressingly small beneficial effect on survival" when used alone or in combinations in patients with "limited disease." Limited disease was defined as "inoperable or nonresectable tumor limited to one hemithorax, without distant metastasis, and of a dimension which can be completely encompassed in a reasonable treatment volume." All other patients were considered to have "extensive disease."

Radiation therapy consisted of a tumor dose between a minimum of 4,000 rads (minimum) and a maximum of 5,000 rads delivered in daily fractions of 150-200 rads, five days per week, in four to five weeks.

Dr. Wolf said it was "of unusual interest" that "the clinical condition of the patient at the outset—the initial performance status—proved to be one

Medicine Said To Fail In Its Use of Nutrients

Medical Tribune Report

NEW YORK—Medicine has generally failed to use nutrients as therapeutic or preventive tools in health care, Dr. Willard A. Krehl, Professor and chairman of the Department of Community Health and Preventive Medicine at Jefferson Medical College, said here.

Speaking at a Nutrition and National Priorities Seminar for Editors and Writers, sponsored by the Vitamin Information Bureau, he cited, as an example of this failure, results of a survey of 35 patient charts selected at random at his own institution. He found that although 14 patients had diabetes, in which "we would presume that a certain caloric level based on height and weight should be established," only seven charts listed weight and four height, and there was a complete failure to record food intake.

of the most reliable predictive factors in prognosis. There was a consistent linear relationship between long survival and the performance rating."

The survival benefit of radiation was better in all studies, Dr. Wolf said, but the effect was seen only in patients with squamous cell tumors and adenocarcinoma.

"Patients with undifferentiated small cell tumors did not benefit in survival through radiation therapy," Dr. Wolf said, "despite the fact that their local tumor response was often striking."

The effect of cytoxin and nitrogen mustard on life span was comparable to radiation therapy, Dr. Wolf said, but he pointed to a "unique" cell-type correlation seen in the response of the agents.

"Patients with poorly differentiated cancer survived longer with cytoxin treatment, while those with squamous lesions did best with nitrogen mustard."

The favorable effect of cytoxin compared to radiation was "persistent" and prompted the testing of radiation and

cytoxin against radiation alone. The combination resulted in the best median survival time, 33.7 weeks, but only for squamous cell cancer.

13th Study In Progress

Protocol 13, begun in April, 1972, is testing radiotherapy plus CCNU (100 mg./M² orally every six weeks) and hydroxyurea (1 gm./M² orally two times a week) against radiotherapy alone. There are now nearly 200 patients in the 13th study, Dr. Wolf reported, not yet enough for a significant statistical assessment.

"Clearly," Dr. Wolf said, "local therapy such as surgery or supervoltage radiation can only be expected to influence the survival of patients with sharply limited local disease of a well-differentiated cell type, and demonstrating a high initial performance status."

"Unhappily," he continued, "the majority of patients with bronchogenic carcinoma, when first seen, are already inoperable because of extensive

local disease and metastases, or prove to have non-resectable tumor on thoracotomy.

"Occult disease, both local and extra-thoracic, must surely have been far greater than the visible portion if we are to explain the poor results of radiotherapy," Dr. Wolf said.

Data from 4,000 autopsies showed that 94 per cent of patients with undifferentiated small cell cancer die with disseminated disease, while 56 per cent of squamous cell carcinomas and 11 per cent of adenocarcinomas remain localized until the patient's death.

"Systemic chemotherapy, in alliance with local radiotherapy," Dr. Wolf said, "would appear to have a better chance of slowing growth and prolonging life."

"However, all of these agents we have tried have had only a minimal and transient effect similar to radiation therapy. It has become perfectly clear as experience has demonstrated with other solid tumors, that more combination chemotherapy regimens must be fashioned and tested, using more effective agents with different actions and toxicity," he said.

Black MD Would Halt Use of Poor In Clinical Trials

Medical Tribune Report

WASHINGTON—A black physician who has been pondering the use of poor patients in clinical experimentation thinks perhaps it should be stopped, at least for enough time to establish some safeguards.

Dr. Henry W. Foster, chairman of obstetrics and gynecology at Meharry Medical College in Nashville, told a news conference here that exemption of the poor from human experimentation is "an alternative that no one has suggested" to counter such situations as the Federal syphilis study in Tuskegee, Ala., in which poor, black, male patients were denied treatment for 40 years.

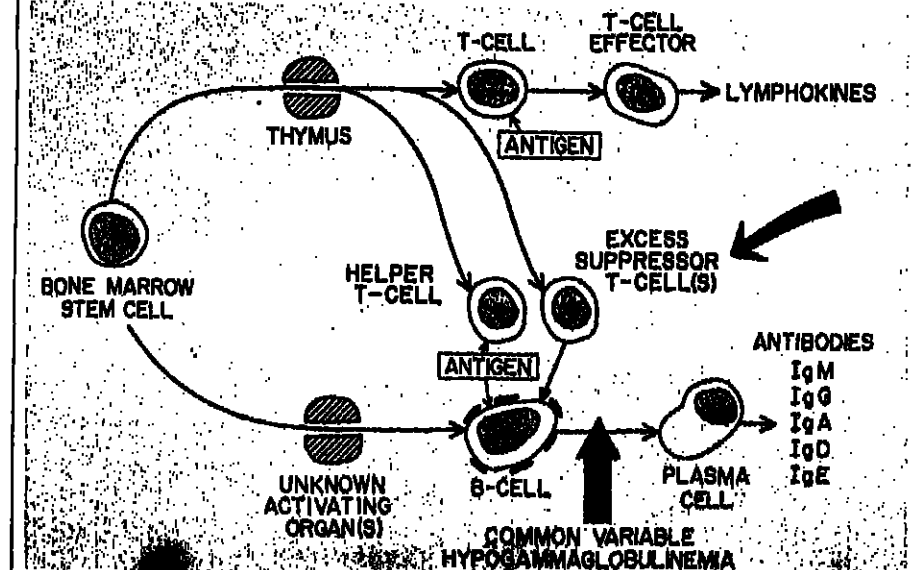
The clandestine aspect of that study, Dr. Foster indicated, was pointed up by the circumstance that "when that story broke, I was president of the Macon County Medical Society in Tuskegee and I'd never even heard of the study."

Planning for Forum

He and two other physicians were here to plan their part of the program—directed toward the plight of the poor—in a two-day forum on human experimentation, which will be sponsored by the National Academy of Sciences Feb. 18-19. Dr. Foster said that his idea of a moratorium on the use of poor people in medical experiments is only "my strong consideration now; I hope to make it firmer by the time of the February forum."

His colleagues on the panel did not completely agree with the concept. Dr. Franz J. Ingelfinger, editor of the *New England Journal of Medicine*, said that exempting the poor might "deprive them of studies theoretically related to their benefit." He questioned, for instance, "how can you improve the vaccination rate for infectious diseases in a poor area without studying the

Immune-Deficiency Disease Can Lead to Cancer



An immune-deficiency disease that sometimes leads to cancer has been discovered by Dr. Thomas Waldman and National Cancer Institute colleagues. Above, drawing shows the complex mechanism of antibody failure in common variable hypogammaglobulinemia (CVH). The large arrow at bottom indicates blockage in normal B-cell maturation into antibody-producing plasma cells. Excessive "suppressor" T-cell production adversely affects B-cell maturation; excessive "suppressor" T-cells are linked to CVH which sometimes results in cancer.

causes for the low rate among the poor?"

Dr. Jay Katz, co-director of the law, science, and medicine program at Yale Law School, also believes that the poor have a large stake for benefit from clinical trials. He noted that "not to experiment with them is also an experiment." Exempting them from experiments, he said, poses dangers of "creating new groups of poor people" who are then "put on waiting lists" for therapy that they urgently need.

But Dr. Katz also said that, from a standpoint of better informed consent, "should not our most knowledgeable and advanced persons be chosen?" He suggested that lotteries or "drafts" of the more privileged patients might have to be conducted to get them into experiments "if society wants it badly enough." He cited an article in a 1968 issue of the *New England Journal*, whose authors found that, for a hypothetical experiment requiring the subject to be infected with malaria, two-thirds

of prisoners said they would participate but absolutely no professionals would.

All three panelists believe that human experimentation is needed for medical advances. They also expressed a variety of doubts about the validity of present procedures for obtaining informed consent from a patient. Dr. Ingelfinger said that true informed consent "doesn't exist unless the patient is a physician in virtually the same field."

Psychological Reorientation

Dr. Katz said that improvement in informed consent requires the investigator "to psychologically reorient himself to accept the subjects almost as co-investigators, with the right to say yes or no."

Dr. Foster indicated that that was precisely that kind of improvement in experimentation that he would like to see established before the poor were brought back into the clinical trial picture.

House Staffers Win 'Rights' In AMA in 3-Hour Walkout

Medical Tribune Report

PORTLAND, ORE.—For three cliff-hanging hours, the American Medical Association lost its young physicians as leaders of 5,000 house staffers walked out in anger at the A.M.A.'s convention here.

They charged the association's leadership had treated them with contempt, refusing to give them jurisdiction over their own affairs within the A.M.A. Further, they charged, the Board of Trustees was planning to flout a just-passed House resolution calling for such rights.

Three hours later, after a hastily convened quorum of the Board of Trustees met their demands, the young physicians returned and informed the relieved House of Delegates they were coming back to the fold.

"We can now serve the A.M.A.," Dr. David A. Axelrad of Fort Ord, Tex., a spokesman for the group, told a press conference—the second that day. "We are withdrawing our resignations and will attempt to make the A.M.A. a force for progress in this country."

Dr. Axelrad, a psychiatrist in the Army Medical Corps, and Chairman of the A.M.A.'s Interns and Residents Business Session (I.R.B.S.), said he would call on the nation's estimated 55,000 house staffers "to join the AMA and help make it a progressive influence for health care."

At issue in the emotion-filled out-again-in-again episode was the 2½-year-old demand by the I.R.B.S. that its elected officers be recognized as the advisory council of the Board of Trustees on matters affecting young physicians. They called on the A.M.A. to abolish the existing House Staff Council, composed of members appointed by the Board as advisory liaison.

'Meaningful Participation'

Dr. Axelrad and his colleagues made it clear before the convention opened that "meaningful participation" (the slogan of their campaign) had become a make-or-break issue, and warned they would resign if this demand were not met. Adding muscle to their threat was the fact that the A.M.A. house staff members had gone on record as agreeing to resign en masse if the demand were rejected at the Portland convention.

Adding even more muscle was the fact, demonstrated in the House of Delegates vote, and in speeches at committee meetings, that a large majority of the older A.M.A. delegates were on the house staff side.

Dr. Robert Harmon of Los Angeles, President of the Physicians National House Staff Association, told the convention: "We are seeking a legitimate input based on our rights. We want evidence of ongoing good faith by the A.M.A. in responding to the initiatives of young physicians."

A California resolution, embodying the demands of the young physicians, and backed by the New York, Wisconsin, and other delegations, was approaching approval in the House after several hours of debate, when Dr. Carroll N. Witten, Chairman of the

Committee on the Constitution and By-Laws, arose to question whether the House had the authority to call for the dissolution of any existing committees, or create new ones. The California resolution had called for elimination of the Committee on House Staff Affairs, its responsibilities to be vested in the I.R.B.S. The House agreed to hold its vote in abeyance until the committee could report.

House Overrides Committee

The following day, the Committee on the Constitution dropped its bombshell. Dr. Witten told the House it had no authority to instruct the Board of Trustees to create new committees or specify their duties.

One angry delegate declared: "In that case, maybe we should have stood in bed."

The House over-rode the Committee on the Constitution and By-Laws and passed the California resolution. But at this point, Dr. Axelrad and his colleagues stalked out of the meeting to read a prepared statement to a press conference, announcing their own resignations and that of all house staff members of the A.M.A.

Dr. Axelrad denounced the action of the Constitution Committee as a "cheap shot" at the young physicians, and said it only confirmed their suspicion that the Board of Trustees was maneuvering to frustrate the will of the House.

"The entire control of the A.M.A.," said Dr. Axelrad, "is under the 15 men, far removed from reality, who make up the Board of Trustees."

He refused pleas by dismayed older physicians, who had supported the resolution, to avoid hasty action. The turning point came when Dr. Russell B. Roth, A.M.A. President and Dr. Richard E. Palmer, Chairman of the Board of Trustees, entered the press

Weight and Height Declared Breast Cancer Risk Factors

Medical Tribune World Service

FLORENCE, ITALY—Weight and height are synergistic risk factors for breast cancer and could help to explain the high incidence of this disease in the West, according to a Dutch prospective study covering more than 7,000 post-menopausal women.

The relative risk in women taller than 5 feet 7 inches and weighing more than 132 pounds was in fact more than five times that of women weighing under 132 pounds, Dr. Frits de Waard, of the Department of Epidemiology, University of Utrecht, told the 21st International Cancer Congress here.

High parity counteracted the risk of high weight, he reported, and single women showed a reduced risk because of their relatively lower body weight. On the other hand, those with a previous mastectomy faced a fivefold increased risk.

During the study, in which 50 general practitioners followed up 7,259 women for an average period of 5.4 years, there were 70 cases of breast

Lose Head, Gain Heart



A biological method for controlling the transmission of malaria by mosquitoes is being studied at the National Institute of Allergy and Infectious Diseases. Robert W. Gwatz, Ph.D., is investigating genetic control of the breeding capacity of *Anopheles* mosquitoes. Since they will not mate in captivity, Dr. Gwatz removes the head of the male (above) which allows the male to continue to live but removes the nerve center that controls the mating instinct. The removal releases the male's inhibitions and allows the headless male to mate.

conference and gave Dr. Axelrad and his colleagues their personal assurances that they would review the recommendation of the California resolution that very day. On that assurance, Dr. Axelrad said the resignations would not be withdrawn but held in abeyance until the board reported back.

Mandate Satisfied

Three hours later, Dr. Roth was given the floor to make a special announcement to the House. He said: "A quorum meeting of the Board of Trustees has agreed to dissolve the House Staff Council and to approve the appointment of the officers of the I.R.B.S. as the Advisory Committee."

In response, Dr. Rex Green thanked the house for its "tremendous support and said: "Our mandate from the interns and residents has clearly been satisfied." N.H.

cancer, compared with an expected 76. Dr. de Waard commented that a correlation between body size and breast cancer is of considerable importance since it may help to explain international variations in incidence. There are many tall and heavy women in Western countries, compared with places like Japan, Taiwan, or Singapore, where breast cancer incidence is low.

ECTOPIC BEAT

One of the odd side effects of the great Tidal Basin affair turned up in an Associated Press dispatch reporting the revival of the undampened Firecracker's ecdysiastic career:

"She said that the current tour would delay her plans to study pre-medicine at the University of Maryland." First things first.

(Regular beats in *Humorists Medicine*, page 28.)

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Circulation audited by Business Publications Audit of Circulation, Inc.

MEDICAL TRIBUNE is published each Wednesday except on Jan. 30, May 29, July 31, and Oct. 30, by Medical Tribune, Inc., 880 Third Ave., New York, N.Y. 10022. Application to mail at controlled circulation rate pending at Pine-land, N.J. 08360.
Subscription \$25.00, Students \$7.50.

Non-Opiate Analgesic, Butorphanol, Seen Promising

Medical Tribune World Service

MEXICO CITY — Preliminary clinical trials of butorphanol, a non-opiate synthetic narcotic antagonist analgesic developed in Canada indicate it could be the strong nonaddictive pain killer that has been sought for generations.

Results of 18 months of testing Butorphanol (levo-N-cyclobutylmethyl-3, 14 beta dihydroxymorphinan) by Dr. Allen B. Dobkin, Professor of Anesthesiology, Upstate Medical Center, New York were presented at the First International Congress of Anesthesiology.

"The activity of butorphanol in man," Dr. Dobkin said, "appears to be ten times more potent than mor-

phine sulfate and 40 times more than pentazocine when injected intramuscularly. These findings are in agreement with the preclinical pharmacological evaluation of the drug in animals. It also has antinarcotic properties of about the same strength as nalorphine which is used to counteract overdoses of such drugs as morphine and demerol."

Dr. Dobkin conducted two double-blind trials comparing it with morphine in 120 patients and with pentazocine in 200 patients who complained of moderate to severe pain usually after major abdominal or orthopedic surgical operations such as cholecystectomy or total hip replacement.

Intensity of pain and relief were

scored for each medicated patient at 30, 60, and 120 minutes on a scale of 0 to 3. After tabulation of the data, scores were analyzed statistically.

Blood pressure and pulse rate varied after analgesic medication with a general trend to a small reduction in systolic blood pressure and pulse rate, Dr. Dobkin said, but the changes appeared to be insignificant and appreciably less than those seen with intravenously administered analgesics.

No patient developed evident respiratory depression, euphoria, or hallucinations after any of the medications, he observed. Substantial pain relief was seen in most instances at the 30-minute observation period. Approximately 90 per cent of the patients

required no remedication within two hours of the study medication.

The only side effect noted in patients with pain was slight drowsiness. In normal volunteers doses higher than 1 mg. were found to be capable of producing lightheadedness, slight nausea, and unsteady gait.

Animal studies carried out by Bristol Laboratories of Canada, the drug's developer in Syracuse and at the University of Michigan, Dr. Dobkin said, appeared to show physical dependence liability to be low and that butorphanol does not substitute for morphine in the withdrawn morphine-dependent rhesus monkey. The evaluation of butorphanol physical dependence in man is currently under investigation at the Addiction Research Center in Lexington, Kentucky.

Wednesday, January 22, 1975

MEDICAL TRIBUNE

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14 of 50 Asthmatic Children Found Intolerant to Aspirin

Medical Tribune Report

SAN FRANCISCO—More than one-quarter of a group of children with chronic asthma were demonstrated to have an intolerance to aspirin by a small study done at the University of California, Los Angeles.

Reporting on the study to the American Academy of Pediatrics meeting here, Dr. Gary Rachelefsky stated that "the results of this investigation strongly suggest the importance of eliminating the use of ASA (aspirin) in children with chronic asthma."

Dr. Rachelefsky reported that 14 of 50 children involved in the double-blind study demonstrated significant small airway obstruction after the ingestion of 300 mg. of aspirin. None had a history of aspirin sensitivity or nasal polyps, and all required continuous medication. The group included 34 males and 16 females, ages 6 to 18, who had had extrinsic asthma for at least five years.

Nine of the 14 aspirin-intolerant patients reacted within 30 minutes, one within an hour, and four after two hours, he continued. In addition, four complained of nausea or abdominal cramping, and three had increased nasal discharge.

Intolerants More Likely Female

Dr. Rachelefsky observed that, when compared with the other 36 patients, the aspirin-intolerant group had more females, an onset of disease prior to two years of age, and more episodes of sinusitis. Both groups showed elevated serum IgE levels and total peripheral eosinophil counts. No difference was seen in dependency on steroids, frequency of eczema or nasal eosinophilia.

When the placebo responses were compared with the aspirin responses in all 50 children, the aspirin challenges were found to produce a significant decrease in pulmonary function, Dr. Rachelefsky noted. This difference was seen even when the 14 aspirin-intolerant patients were removed.

Dr. Rachelefsky observed that adults with aspirin-induced asthma appear to be a heterogeneous group not distinguished by a particular disease pattern until the third or fourth decade, when intermittent rhinorrhea develops, progressing to chronic nasal blockage and occurrence of nasal polyps, and later asthma, which is resistant to the usual medications and requires steroid treatment for control.

The present study, he said, "suggests that intolerance may develop before adulthood, even without nasal polyps or severe nasal symptoms," and

may be a different entity than the adult disease.

Dr. Rachelefsky suggested that intolerant patients may fail to make an association between ingestion of aspirin or an aspirin compound and a provoked or intensified asthma attack because of the delayed reaction.

Also, he continued, many compounds contain aspirin or other compounds known to precipitate asthma in aspirin sensitive patients, unknown to the patient. In this latter group he included indomethacin, metanamic acid, tartrazine (a yellow coloring material used in soft drinks), canned vegetables, and some medications.

African Nurse-Midwives Study in California



Six nurse-midwives from five African nations are intensively studying family planning, women's health, and child care at Harbor General Hospital in Torrance, California in order to apply modern methods to their native countries. Above, Mrs. Hope Simelane from Swaziland practices examination techniques for breast cancer while the other students look on.

Merrell

Tenuate®
(diethylpropion
hydrochloride N.F.)

BRIEF SUMMARY

INDICATIONS: Tenuate is indicated in the management of excessive obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states.

Warnings: Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crisis may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There are occasional reports of subjects dependent on amphetamine later chronically abusing diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage in many cases that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, parotid swelling, irritability, hyperreflexia, and personality changes. The most severe manifestation of chronic intoxication is psychosis, often clinically indistinguishable from schizophrenia.

Use in Pregnancy: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks.

Use in Children: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension.

Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen.

Tenuate may decrease the hypotensive effect of guanethidine. The total amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure, discomfort, pain, arrhythmia. One published report described 7-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride.

Central Nervous System: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses. In a few subjects an increase in convulsive episodes has been reported.

Gastrointestinal: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances.

Adipose: Urinary, fecal, cutaneous, excretory.

Endocrine: Impotence, changes in libido, menstrual upset.

Hematopoietic System: Bone marrow depression, agranulocytosis, leukopenia.

Adverse Reactions: A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dyspnea, hiccups, muscle pain, cystitis, and polyuria.

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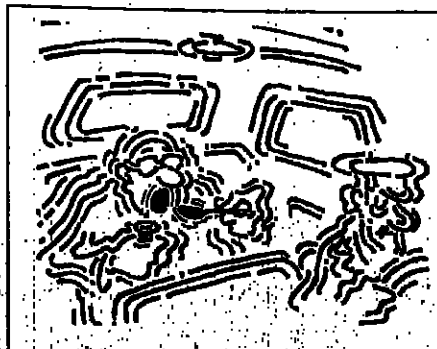
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from Wyeth

Wygesic

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65 mg. propoxyphene HCl, U.S.P.
and
650 mg. acetaminophen, N.F.

Wyeth



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Current Opinion

This Is Medical Ethics?

By DR. CHARLES B. MOORE
Department of Internal Medicine
Alton Ochsner Medical Foundation
and Ochsner Clinic, New Orleans

Excerpted from the Hastings Center Report of the Institute of Society, Ethics and the Life Sciences, Hastings-on-Hudson, N.Y. 10706

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Dr. Gardner's denial that ethics were an issue was challenged by some delegates, who noted that at least one of the board's statements, as well as a widely publicized comment by Dr. James H. Sammons, executive vice-president, had alluded to ethics as a consideration in the advertising decision.

Dr. George Himler of New York said he failed to understand why ad-

vertising should be viewed as a net loss. "If it costs about \$15,000,000 to publish the A.M.A. journals, and advertising brings in \$8,500,000, that's not a loss, that's an offsetting figure."

Dr. Roman E. Gainsinski of Milwaukee added: "If there is presently no profit in advertising, then changes should be made to create a profit." As a start, he urged the discontinuation of *Prism*, "which is losing \$1,000,000 a year."

Several Sets of Numbers

"The problem is," said Dr. Philip G. Thompson of Dolton, Ill., "that we've received several sets of numbers and we can place no credence in any." Introduced by Dr. Raymond T. Holden of Washington, a trustee, who noted that A.M.A. advertising is currently

under scrutiny of the Internal Revenue Service, which tends to regard advertising income as income not related to the associations nonprofit status.

"We are faced with a potential tax liability for unrelated income," Dr. Holden reported. "We admit absolutely no income from advertising. Our overall cost of publications is between \$13,000,000 and \$15,000,000, and advertising income is projected at \$8,600,000. There's a discrepancy of \$5,000,000 in round figures."

"Nevertheless, our potential tax liability could be tremendous. If we lost, we'd have to give the IRS our headquarters building."

Despite this gloomy forecast, the committee moved to recommend that the House go on record as supporting advertising "in principle," an action that the House took almost without debate. N.H.

The overweight diabetic... trapped by her own fat cells.

If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower her blood sugar is a drug that stimulates more insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

DBI-TD Geigy
phenformin HCl

Lowers blood sugar without raising blood insulin.



DBI® phenformin HCl. Tablets of 25 mg. DBI-TD® phenformin HCl. Timed-Disintegration. Capsules of 50 and 100 mg.

Indications: Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus. **Contraindications:** Diabetes mellitus that cannot be regulated by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; a history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; cardiovascular collapse (shock); after disease states associated with hypoxemia. **Warnings:** Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

- a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum urea nitrogen, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.
- b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.
- c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.
- d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, uricemia has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.
- e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.
- f. Warn patients against using alcohol in excess while receiving phenformin,

since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.

"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoadicidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

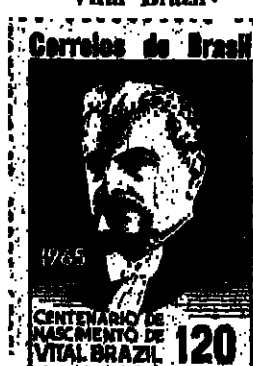
Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal: unpleasant metallic taste, coating to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, uricemia has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(5998-140-102-G (8/74))
For complete details, including dosage, please see full prescribing information. GEIGY Pharmaceuticals Division of CIBA-GEIGY Corporation, Ardley, New York 10502.

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Text: Dr. Joseph Klar
Stamp: Minkus Publications, Inc., New York

Current Opinion

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Wednesday, January 22, 1975

MEDICAL TRIBUNE

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Dr. Gardner's denial that ethics were an issue was challenged by some delegates, who noted that at least one of the board's statements, as well as a widely publicized comment by Dr. James H. Sammons, executive vice-president, had alluded to ethics as a consideration in the advertising decision.

Dr. George Himler of New York said he failed to understand why ad-

vertising should be viewed as a net loss. "If it costs about \$15,000,000 to publish the A.M.A. journals, and advertising brings in \$8,500,000, that's not a loss, that's an offsetting figure."

Dr. Roman E. Galasinski of Milwaukee added: "If there is presently no profit in advertising, then changes should be made to create a profit." As a start, he urged the discontinuation of *Prism*, "which is losing \$1,000,000 a year."

Several Sets of Numbers

"The problem is," said Dr. Philip G. Thompson of Dolton, Ill., "that we've received several sets of numbers and we can place no credence in any," introduced by Dr. Raymond T. Holden.

Another factor in the dispute was introduced by Dr. Raymond T. Holden of Washington, a trustee, who noted that A.M.A. advertising is currently

under scrutiny of the Internal Revenue Service, which tends to regard advertising income as income not related to the associations nonprofit status.

"We are faced with a potential tax liability for unrelated income," Dr. Holden reported. "We admit absolutely no income from advertising. Our overall cost of publications is between \$13,000,000 and \$15,000,000, and advertising income is projected at \$8,600,000. There's a discrepancy of \$5,000,000 in round figures."

"Nevertheless, our potential tax liability could be tremendous. If we lost, we'd have to give the IRS our headquarters building."

Despite this gloomy forecast, the committee moved to recommend that the House go on record as supporting advertising "in principle," an action that the House took almost without debate. N.H.

The overweight diabetic... trapped by her own fat cells.

If only she would diet, her blood sugar might come down. Her high levels of blood insulin might come down, too. This may be important in the overweight diabetic since insulin is the "storage hormone" that transports glucose into adipose tissue. Maybe the last thing the overweight diabetic needs to lower her blood sugar is a drug that stimulates more insulin secretion.

If dieting doesn't work in the overweight, nonketotic, adult-onset diabetic, consider adding DBI-TD.

DBI-TD® Geigy
phenformin HCl

Lowers blood sugar without raising blood insulin.



DBI® phenformin HCl. Tablets of 25 mg. DBI-TD® phenformin HCl. Timed-Diintegration Capsules of 50 and 100 mg.

Indications: Stable, adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of variable diabetes mellitus.

Contraindications: Diabetes mellitus that can be regulated by diet alone; hypersensitivity to phenformin; renal disease with impaired renal function; a history of lactic acidosis; alcoholism; juvenile diabetes mellitus that is uncomplicated and well regulated on insulin; acute complications of diabetes mellitus (metabolic acidosis, coma, infection, gangrene); during or immediately after surgery where insulin is indispensable; severe hepatic disease; cardiovascular collapse (shock); after disease states associated with hypoxemia.

Warnings: Lactic Acidosis: There have been numerous reports of lactic acidosis in patients receiving phenformin. This is an often fatal metabolic acidosis, characterized by elevated lactate levels, an increased lactate-to-pyruvate ratio, and decreased blood pH. In most cases, azotemia ranging from mild to severe was present. This may have been the result of dehydration. In some patients who developed lactic acidosis, serum creatinine was later within normal limits when the patients were properly hydrated. Observe the following specific warnings:

- a. Impairment of renal function increases the risk of lactic acidosis. Perform renal function tests, such as serum creatinine, prior to phenformin therapy and annually thereafter. Phenformin is contraindicated in patients with impaired renal function.
- b. Cardiovascular collapse (shock), congestive heart failure, acute myocardial

infarction, and other conditions characterized by hypoxemia have been associated with lactic acidosis and also may cause prerenal azotemia. Use of phenformin in patients likely to develop such conditions must be carefully considered. Discontinue phenformin promptly when such events occur.

c. Gastrointestinal disturbances are the most common adverse reactions of phenformin therapy and must be distinguished from the prodrome of lactic acidosis. Anorexia and mild nausea are not uncommon side effects, particularly upon initiation of therapy. Nausea, vomiting, malaise, or abdominal pain may herald the onset of lactic acidosis. Instruct the patient to notify the physician immediately should any of these symptoms or hyperventilation occur. Withdraw phenformin until the situation is clarified by determination of electrolytes, and, if necessary, pH, blood sugar, ketones, lactate, and pyruvate.

d. Lactic acidosis has a significant mortality. When suspected, discontinue phenformin and institute bicarbonate infusions and other appropriate therapy, even before the results of lactate determinations are available. It should be suspected in the presence of a metabolic acidosis in any diabetic patient lacking evidence of ketoacidosis (ketonuria and ketonemia) and not intoxicated with methanol or salicylates, or not in uremic acidosis.

e. Use special caution after initiation of phenformin therapy, after increase of drug dosage, and in circumstances that may cause dehydration leading to impaired renal function.

f. Warn patients against using alcohol in excess while receiving phenformin.

since ethanol and phenformin potentiate the tendency of each to cause an elevation of blood lactate levels.

Pregnancy: Use during pregnancy is to be avoided.

Precautions: Starvation Ketosis: This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria, in spite of relatively normal blood sugar with little or no urinary sugar. This may result from excessive phenformin therapy or insufficient carbohydrate intake.

"Destabilization" of Previously Controlled Diabetic: When laboratory abnormalities or clinical illness develop, evaluate electrolytes, pH, lactate, pyruvate, and blood and urine ketones for evidence of ketoacidosis or lactic acidosis. With either form, withdraw phenformin and institute corrective therapy.

Hypoglycemia: Although hypoglycemic reactions are rare when phenformin is used alone, every precaution should be observed during the dosage adjustment period particularly when insulin or a sulfonylurea has been given in combination with phenformin.

Adverse Reactions: Principally gastrointestinal: unpleasant metallic taste, continuing to anorexia, nausea and, less frequently, vomiting and diarrhea. Reduce dosage at first sign of these symptoms. In case of vomiting, the drug should be immediately withdrawn. Although rare, urticaria has been reported, as have gastrointestinal symptoms such as anorexia, nausea and vomiting following excessive alcohol intake.

(NDA-148-100-3 (8/74))

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals

Division of CIBA-GEIGY Corporation

Arjany, New York 10502

Medicine on Stamps

Vital Brazil



Vital Brazil (1865-1950) was one of the earliest investigators of snake venom. Working in São Paulo, he developed a model laboratory and one of the earliest and largest for the production of snake antivenom serum. This laboratory (the Butantan Institute), now assisted by the Rockefeller Foundation, sends such serum all over the world.

Text: Dr. Joseph Kier
Stamp: Minkus Publications, Inc., New York

If there's good reason
to prescribe
for psychic tension...



Prompt action
is a good reason
to consider Valium®
(diazepam)

When, for example, despite

When your patient's somatic complaints are associated with tension and anxiety and you have tried counseling and other supportive measures alone, you may decide to prescribe psychotherapeutic medication. If you do, the question remains: Which one?

Valium (diazepam) is one to consider closely. One that works promptly as an adjunct to continued supportive measures. One that generally produces significant improvement within

counseling, tension and anxiety continue to produce distressing somatic symptoms

the first few days of therapy, although some patients may require more time for a clear-cut response.

Prompt action. One good reason to consider Valium (diazepam).

And should you choose to prescribe Valium, you should also keep this information in mind: Valium is usually well tolerated; the most common side effects reported have been drowsiness, fatigue and ataxia.

As with all CNS-acting agents, patients should be cautioned against operating dangerous machinery or driving. Normally, therapy with Valium (diazepam) should be continued until the patient's psychic tension symptoms have been reduced to tolerable levels.

Please turn page
for a summary of product
information.

Valium® ROCHE
(diazepam)
2-mg, 5-mg, 10-mg tablets

Other good reasons to consider Valium® (diazepam)

Effectiveness

The efficacy of Valium (diazepam) has been proven in clinical studies and in extensive clinical use. It can relieve psychic tension and its somatic symptoms in patients who overreact to stress and in psychoneurotic patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or

Dependable response

The psychotherapeutic effect of Valium (diazepam), characterized by symptomatic relief of tension and anxiety, is generally reliable and predictable.

severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in

Titratable dosage

With Valium (diazepam), adjustments in dosage can alter the clinical response. This titratability enables you to tailor your therapy for maximum efficiency. There are three convenient tablet strengths to choose from: 2 mg, 5 mg and 10 mg.

salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



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Medical Tribune

and Medical News
Published by Medical Tribune, Inc.

H.E.W. Sets Policy to Police Doctors

headline, N.Y. Times, Nov. 29, 1974

WORSHIPERS of cost efficiency, the "slide-rule boys" "computer geniuses," and management consultants in the Department of Health, Education and Welfare have been very clever. They publicly cloak each new regulatory proposal with a claim for "quality" and "efficiency" as they privately acknowledge that their prime objective is cost control of health care services—cost control of services for patients as well as the practices of physicians. First, they moved to control new drug research and the introduction of new medicines, then how the doctor should use them. They now propose, in the words of the *New York Times*, "to police" physicians' practices in hospitalizing patients.

As to future availability and flexibility of health services, look perceptively at this statement:

"The utilization review procedures spelled out in these regulations will improve the overall quality of care provided to Medicare and Medicaid beneficiaries and increase the overall efficiency of our total health care system," said Caspar W. Weinberger, H.E.W. Secretary in establishing procedures to review whether the patient's stay in the hospital is justified.

Let us note clearly that the new regulations referred to will take effect in February. They will require a review after the patient is admitted to see if hospitalization is justified. Reported, "The review would be conducted on the first day by nurses and technicians. The final decision would be made on the second day by groups of doctors." Let's face facts—the fewer the services and the shorter the hospitalization, the lower the cost. Cost efficiency, not quality of medical care, is Caspar Weinberger's specialty.

It would appear that the judgment of a patient's physician is first to be reviewed by non-physicians. Whereas nurses of necessity have had access in the past to patient's records, the government now seeks to formalize a new and massive invasion of patient privacy and of the confidentiality of the doctor-patient relationship. Traditionally, patient records have not been officially accessible without the patient's approval, even to other physicians. Now, they are to be officially opened to nurses other than those caring for the patient, to technicians, as well as to doctors other than those directly charged with the patient's care. This is a policy not only "to police doctors," it is to "police patients" by interjecting a government mandated policing body into the physician-patient relationship.

Caspar Weinberger himself lets the "cat out of the bag":
"In addition," he said, "it is anticipated that the new regulations will save millions of dollars a year by eliminating unnecessary hospitalization and unneeded services and procedures." (*New York Times*, Nov. 29, 1974, p. 19)

"Unnecessary hospitalization and unneeded services and procedures" by whose standards? Ultimately, H.E.W. standards, not those of the patient's physician.

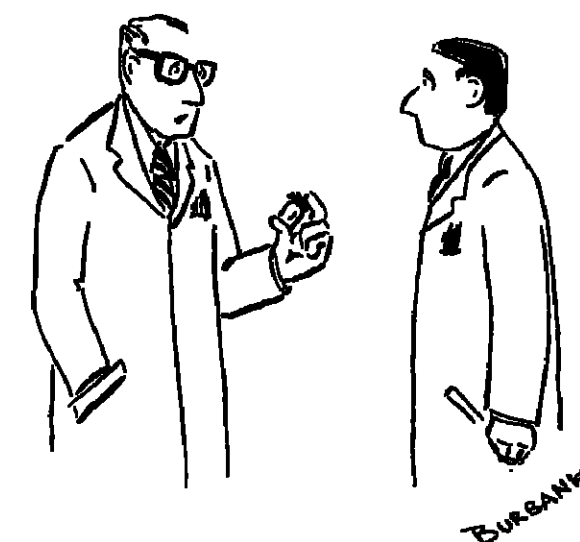
Let us be very blunt. Caspar Weinberger's nickname (Cap the Knife) derives from cost cutting, not from surgical skill and not from improvement in quality and extent of health services.

H.E.W. estimates its utilization review will produce a five-months' savings of \$40 million in Medicare and Medicaid in 1975. The hypothetical savings of about \$100 million a year should be viewed against the projected costs of the two federal health programs—of \$20 billion for 1974. For this massive governmental intervention is thus claimed an estimate of savings, if there be any, of one-half of one percent of costs.

As is usual in such situations, nothing is said about administrative costs to supervise the program. Considering the shortage of doctors and nurses as well as technicians, can a hypothetical saving of one-half of one percent at the cost of valuable time of health professionals in short supply be justified? We have an Army, Navy and Air Force, and spend billions of dollars to protect American freedoms, one of which—confidentiality, the right of privacy—will now be sold out for the price of about two dozen Phantom jet fighters. Efforts by the Nixon administration to subvert the Justice Department, key government agencies and the Treasury Department brought America close to the brink of a new type of dictatorial control.

Astonishingly, the drive for national health insurance legislation proceeds without discussion of patient privacy and totally devoid of safeguards for the confidentiality of patients. The public and our patients should be alerted to the fact that under the cover of "utilization review," cost efficiency, and the pretense of "quality control," men from the prior Presidential administration are seeking through the regulatory actions of H.E.W. to legally breach the same physician-patient relationship whose violation in the past led to the resignation of a president.

Let's be blunt about it. "H.E.W. SETS POLICY TO POLICE DOCTORS" and proposes "a program directed at POLICING PATIENTS."



"Bad news on the new safety cap you developed, Nasworthy. Nobody can open it."

©1975 Medical Tribune

LETTERS TO TRIBUNE

TV Trauma Teacher

After many years of watching national TV, especially on Saturday and Sunday afternoons, I am forced at this time to voice my pentup emotions relative to the glaring errors that are repeatedly committed before millions of viewers week after week.

One doesn't have to wait for more than one full quarter of play during any collegiate or professional football game to view an injury in the making or after the fact. What usually happens, thereafter, is testimony to complicating the injury as one might compare converting a misdemeanor to a felony.

The typical case is a clipping injury with a large hulk of a player lying on the turf writhing in agony holding his knee. A trainer first runs out followed, usually, by a coach and the team physician.

The next sequence of events is what is most disturbing and probably as injurious or even more so than the injury itself. The trainer and the doctor—or more likely too, small defensive backs—come on the field to drag off a huge tackle from somewhere mid-field to behind the sidelines. Usually the injured extremity is dragging and bobbling behind unsupported and unprotected. It is quite obvious to even the untrained eye that further injury could be sustained all along the way.

Even at our junior high school level, coaches and trainers are taught to avoid further complicating an injury. A local rule is that a stretcher must be at the sidelines and an ambulance in attendance for swift delivery to the local emergency room. It is a rare sight to see a stretcher brought out on a nationally televised ballgame in order to transport an injured player properly and efficiently and avoid further insult to the damaged part.

Colleges, high schools and all down the line copy what they see and certainly professional football is the ultimate in every respect. Surely, this must be as obvious to those in positions of responsibility as it is to this observer. If management isn't too concerned about what the public sees in this regard, they must have some awareness as to the potential hazard to their

major investment, namely the ball-player himself.

My plea, at this time, is for a stretcher to be used at any time when a ballplayer cannot completely and safely navigate himself from the field of play after an injury.

PHILIP O. LICHTBLAU, M.D.
West Palm Beach, Fla.



Superb

About Dr. Alan L. Goldberg's comments in *Infection Control Today* (MT, Dec. 11):

Just to say superb, practical, clinical and purposeful. Your handling of the subject (upper respiratory infections) makes me proud of family physicians and Med Tribune too.

Your style of presentation was most enjoyable. Just believe this: You said more practical, clinical things than what I hear at symposia from the pros who do not treat patients for a fee but honoraria.

HARRY H. HORWITZ, M.D., F.A.A.P.
Oakland, Calif.

We're sorry we transposed Dr. Sumner Marshall's name in reporting (Dec. 25) his views on enuresis presented at the American Academy of Pediatrics recent meeting.—Ed.

New Techniques Cut Deaths In Patent Ductus Arteriosus

Medical Tribune Report

NEW ORLEANS—A new, noninvasive diagnostic technique and a surgical protocol for ligating a patent ductus arteriosus are said to have reduced the mortality of infants at Huntington Memorial Hospital's neonatal center in Pasadena, Calif. to 10.4 per cent. The new techniques were reported here to the 40th Annual Scientific Assembly of the American College of Chest Physicians.

Dr. L. Stephen Gordon, pediatric cardiologist at the Pasadena Cardiology Medical Group, Inc., told the college that brachial arterial Doppler ultrasonography for diagnosing patent ductus arteriosus (PDA) "is a perfectly safe, noninvasive procedure that has none of the hazards of cardiac catheterization in a small, sick, premature infant." He and his colleagues, Dr. Paul E. Johnson, Hilton Bugge, and Charles Prickett, reached this conclusion after 41 tests of the Doppler technique on 38 infants with a cardiac murmur typical of PDA.

Until now, diagnosis has been made

from clinical signs or catheterization, but, Dr. Gordon stated, "Previous reports . . . of the changes in the peripheral arterial pulse wave in various cardiac diseases led us to look at the peripheral arterial pulse wave in infants whom we suspected to have a patent ductus arteriosus."

Size of Shunt Indicated

The Doppler tracings, made with a directional Doppler coupled transcutaneously to the infant's skin with special electrode gel, gave dramatically different readings for forward and reverse flow velocity in normal infants and in those with suspected PDA, Dr. Gordon said. The tracings also indicated the size of the shunt. Quantitative and qualitative analysis of the data appeared to approximate the degree of left-to-right shunting through the ductus, Dr. Gordon added.

Sixteen of the infants in Dr. Gordon's Doppler tests were among the 20 operated for PDA ligation by Dr. Carter A. Printup, thoracic cardiovascular surgeon at Foothill Cardiothoracic Surgery Medical Group, Inc. in Pasadena.

"We kept accurate records to determine not only the results, but a profile of the infant that would benefit from the procedure," Dr. Printup stated. The gestation age of all the infants was 25 to 38 weeks, all revealed systolic murmur, and the average age at surgery was eight days. The new Doppler technique was used for diagnosis in a number of cases. Only those infants with progressive cardiac failure, increasing oxygen demands, and respiratory failure (despite mechanical ventilator) were operated.

Surgical Procedure

The surgical approach was through a left thoracotomy. The lung was retracted anteriorly and the ductus exposed, encircled and ligated. Halfway through the series, the suggestion was made to clip the ductus. "This was much easier than tying since, in these small infants, the exposure is understandably narrow," Dr. Printup said. "From then on, the ductus was obliterated by a hemoclip at each end."

Nonfatal postoperative complications included pneumothorax (seven cases), cerebral hemorrhage (two), pneumonia (three), and necrotizing enterocolitis and sepsis (one). Three infants died, one from a surgery-related pulmonary artery thrombus.

Dr. Printup divided the infants into three groups, in descending order of their chances of benefitting from the operation:

- Premature infants with respiratory problems caused solely by the large ductus.
- Those with the same problems who also require progressive oxygen settings to maintain adequate PO_2 .
- Those with hyaline membrane disease complicated by PDA.

"Surgical obliteration of the patent ductus is definitely beneficial in the first two groups and may be so in the third group," he concluded.

Coauthors were Drs. Johnson and Gordon, Dr. William R. Dietrick, J. R. F. Penido, and B. H. Cotton.

'High'-Performance Driver Scores Low



Bob Bondurant, of the Bondurant School of High Performance Driving, expresses surprise at his low score after having driven a test course under the influence of alcohol in the segment "How Drinking Affects Driving."

Prize-Winning Health Series Now on National Network TV

NOW TO BE broadcast nationally on network television, MEDIX is a weekly 30-minute series on medicine and health designed to provide the public with health care information. Started in Los Angeles and produced with the cooperation of the L. A. County Medical Association and many leading health-related organizations, the series has won numerous awards and commendations in the two years since it was started. This reception led Burroughs Wellcome to decide to sponsor it nationally, starting this month. Shown are some of the scenes from the series.



"Disaster Drill," left, attempts to show how best to react to a major disaster. Above, comedian Marty Allen submits to a demonstration of mouth-to-mouth resuscitation.



Dr. John Boyer, of the President's Council on Physical Fitness, talks to host Mario Machado on the segment "Fitness Fun For All," describing how everyone can stay in shape and enjoy it.

Intractable Enteric Bacillus Menaces U.S. Burn Centers

Continued from page 1

among patients who would have been kept alive—except for the *P. stuartii* invasion.

When Providencia was first seen in burns in 1969, most strains were resistant to most drug therapies, Dr. Lindberg said. By 1972, this previously obscure species of enteric bacillus had acquired "total refractoriness" to all systemic or topical antibiotic therapy. The situation, he said, "is unprecedented and alarming."

Clearly, in the past number of years, there have been fluctuations in the species infecting burn wounds, Dr. Lindberg stated. "In the 1950s, staphylococci and hemolytic streptococci were major offenders while late in that decade an overwhelming preponderance of *Pseudomonas aeruginosa* appeared in burns." These were controlled largely by such topical chemotherapy as silver nitrate and sulfamylon.

Unexpected Rise in 5 Years

A more varied wound flora then appeared, dominated by staphylococci and fecal flora. And during the past five years, along with a rise in pulmonary complications and subsequent sepsis has been an unexpected increase in the incidence of *P. stuartii*.

There appears to be frequent cross-transmission from patients who have been in hospital to new arrivals. Incoming patients are found to harbor the organism within a week, "and its eradication from the burn ward thus becomes even less feasible." At the same time, Dr. Lindberg noted, patients admitted to the burn ward six to 10 days post injury are often already infected. "The proportion of positive wound swabs rose from eight per cent to 28 per cent by 1970," he said. Sputum samples rose at an even

greater rate: 15 per cent were positive in 1965 and 60 per cent in 1972, with rates unchanged today.

P. stuartii is by far the most common gram-negative species in their patients. Although *Staph aureus* is ubiquitous on burn wounds, it has rarely been involved in patients with invasive sepsis. In addition, Providencia is the most common species recovered by biopsy of tissue beneath the burn surface, Dr. Lindberg said—55 per cent of all patients are positive. Since 1968, Providencia has consistently been the most common, predominant gram-negative species in biopsied burn wounds at the Fort Sam Houston Center.

Death Rate Reaches 72 %

As early as 1966, Providencia was the least common species in bacteremic episodes, appearing in only one of every ten patients with positive blood cultures. But, by 1970, the figure had jumped to half of the bacteremic patients. Particularly disturbing to the Texas group is that when burn patients have a staphylococcal or *Pseudomonas* bacteremia, fewer than 20 per cent die; when Providencia was associated with bacteremia, the fatal outcome—between 1969 and 1971—was 30 to 40 per cent. By 1973, "72 per cent of all patients with positive blood culture for Providencia *stuartii* died."

Post-mortem studies on a number of burn patients revealed the rampaging nature of *P. stuartii*. The preponderance of Providencia in lung, liver, spleen, and burn wounds in these patients was very high, Dr. Lindberg said. In contrast, in these tissues, the incidence of staphylococci was low in all sites except the wound itself. The high incidence of Providencia *stuartii* has continued with brief episodes of fluctuation, to the present.

"While it is not possible to ascribe to any organism an unequivocally lethal role, the results of these cultures correlated closely with a high death rate among patients with Providencia sepsis," he declared.

Almost Unstoppable

The major problem is that the organism appears, at this stage, to be almost unstoppable, Dr. Lindberg indicated. In 1969, the proportion of strains sensitive was low. "Colymycin and gentamicin showed a moderate increase in effectiveness in 1970, but then resistance increased rapidly. By 1972, there were no strains sensitive to these or any other antibiotics obtainable.

"This is a totally resistant population of bacteria. Resistance transfer factor cannot be demonstrated, but in any event, an extensive and total resistance currently permeates this important population."

Recently, a new, experimental antibiotic (amikacin) has been tested against *Prov. stuartii*. *In vitro*, 50 per cent of the strains were inhibited at 12.5 mcg./ml., and 25 per cent at 6.25 mcg./ml. Although they have not yet extended the study clinically, they term these results an "encouraging development."

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states! That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.

EMPIRIN[®] COMPOUND & CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3 ¼, phenacetin gr 2 ½, caffeine gr ½.

* Warning—may be habit-forming.



Burroughs Wellcome Co. Research Triangle Park, North Carolina 27709

Misdiagnoses Snag Sicklemia Screenings

Continued from page 1

Many misdiagnoses, Dr. Bowman explained, result from faulty interpretation of data from electrophoretic devices that separate various types of hemoglobin on the basis of their behavior in an electric field. In some cases, hemoglobin variants, harmful or otherwise, show essentially the same electrophoretic behavior and can be misinterpreted without the proper laboratory follow-up.

It is often difficult to distinguish between a diagnosis of the sickle trait, which is essentially harmless to the carrier and B-thalassemia, a serious hemoglobin abnormality Dr. Bowman explained. Only the proportions of normal hemoglobin (HbA) and sickle cell hemoglobin (HbS) differ in the two conditions, he said, citing a case of a young man who had a history of crisis, pain, anemia, and weakness and was diagnosed as HbS. A later quantitative diagnosis showed he had B-thalassemia.

"If we had not done that diagnosis, the young man would have been considered a sickle cell trait carrier for the rest of his life and might have found his way into the literature as another example of sickle cell trait with crises," Dr. Bowman said, again emphasizing that there is no strong evidence suggesting that sickle cell carriers can expect anything other than a normal life.

A Father With 'Silent Gene'

Citing another case in which a child had B-thalassemia, Dr. Bowman pointed up the difficulties that occur when analysis showed that the mother had sickle cell trait and the father appeared to be normal (HbA). Genetically, the combination should not have produced thalassemia, but the mother insisted that her husband was the father. A second analysis Dr. Bowman said, showed that she was correct and that the father had a "silent gene" for thalassemia.

In another instance, a boy was diagnosed as having sickle cell anemia, and it was not until 4 years later, after much anxiety on his part and the part of his parents, that it was determined that the boy only had the sickle cell trait, Dr. Bowman said.

WHO Asks Cash, Vaccines

Medical Tribune World Service

GENEVA—A special account under the Voluntary Fund for Health Promotion, created this year to step up worldwide immunization programs against such childhood infections as diphtheria, whooping cough, tetanus, poliomyelitis, and measles, is seeking donations of cash and vaccines for countries in need, WHO has announced.

Although vaccines against these and other diseases have existed for decades, millions in other countries, particularly in the tropics, suffer and die needlessly from lack of funds and manpower to provide immunization, WHO said.

The Voluntary Fund, based here and created in 1960, is used for activities beyond WHO's regular budget of \$115,000,000 for 1975.

Agreeing that inadequate screening programs may be more trouble than they are worth, Dr. David Satcher of the King-Drew Medical Center in Los Angeles complained that screening for sickle cell trait is pointless if it cannot be followed up by competent genetic counseling.

Legal and Job Problems Cited

"There are just not enough physicians and adequately trained health professionals to do the kind of genetic counseling we have been saddled with since the mass screening programs were initiated," he said, noting that the misunderstanding of sickle cell trait and its implications often leads to legal and employment problems for the affected individual.

"Recently in a Los Angeles County agency, a physician had been routinely turning down all applicants for a job who had the sickle cell trait and the only way we found out about it was because of the persistence of a young woman who had applied for the position and who felt she was being erroneously discriminated against," Dr. Satcher said.

Based on a recent survey carried out in Los Angeles, Dr. Satcher suggested that as long as mass screening programs persist in their present form, those who attempt to do genetic counseling must be aware of the environment of misinformation in which the programs are carried out.

"When we talk about sickle cell trait and carrier states, the first thing that

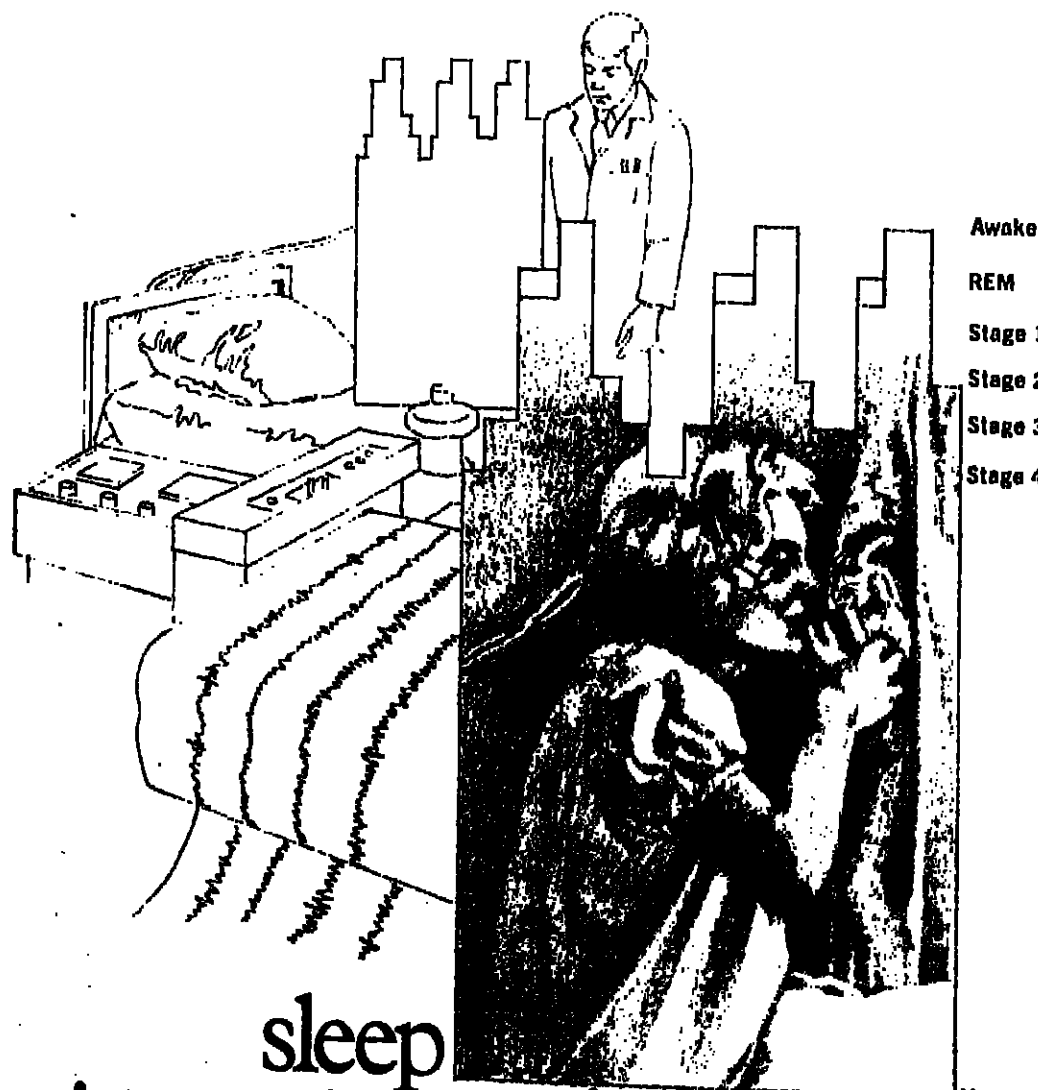
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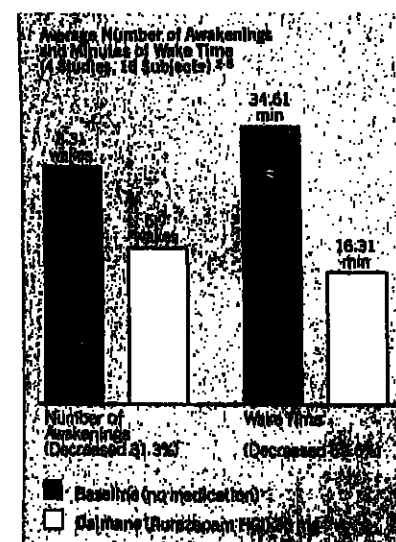
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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

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REFERENCES: 1. Kales J, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug, 1971
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The report has presented by Drs. Pierre Clement, Frederick Andermann, and Maurice Dugier, of Montreal Neurological Hospital and Allan Memorial Institute, McGill University.

In commenting on their patients, they asked:

"When they come close to the TV screen, are they, like Alice in Wonderland, trying to go beyond the mirror? When they lose consciousness, are they, like the dreamer, reaching for the lost object which they are mourning?"

Misdiagnoses Snag Sicklelema Screenings

Continued from page 1

Many misdiagnoses, Dr. Bowman explained, result from faulty interpretation of data from electrophoretic devices that separate various types of hemoglobin on the basis of their behavior in an electric field. In some cases, hemoglobin variants, harmful or otherwise, show essentially the same electrophoretic behavior and can be misinterpreted without the proper laboratory follow-up.

It is often difficult to distinguish between a diagnosis of the sickle trait, which is essentially harmless to the carrier and B-thalassemia, a serious hemoglobin abnormality Dr. Bowman explained. Only the proportions of normal hemoglobin (HbA) and sickle cell hemoglobin (HbS) differ in the two conditions, he said, citing a case of a young man who had a history of crisis, pain, anemia, and weakness and was diagnosed as HbS. A later quantitative diagnosis showed he had B-thalassemia.

"If we had not done that diagnosis, the young man would have been considered a sickle cell trait carrier for the rest of his life and might have found his way into the literature as another example of sickle cell trait with crises," Dr. Bowman said, again emphasizing that there is no strong evidence suggesting that sickle cell carriers can expect anything other than a normal life.

A Father With 'Silent Gene'

Citing another case in which a child had B-thalassemia, Dr. Bowman pointed up the difficulties that occur when analysis showed that the mother had sickle cell trait and the father appeared to be normal (HbA). Genetically, the combination should not have produced thalassemia, but the mother insisted that her husband was the father. A second analysis Dr. Bowman said, showed that she was correct and that the father had a "silent gene" for thalassemia.

In another instance, a boy was diagnosed as having sickle cell anemia, and it was not until 4 years later, after much anxiety on his part and the part of his parents, that it was determined that the boy only had the sickle cell trait, Dr. Bowman said.

WHO Asks Cash, Vaccines

Medical Tribune World Service

GENEVA—A special account under the Voluntary Fund for Health Promotion, created this year to step up worldwide immunization programs against such childhood infections as diphtheria, whooping cough, tetanus, poliomyelitis, and measles, is seeking donations of cash and vaccines for countries in need, WHO has announced.

Although vaccines against these and other diseases have existed for decades, millions in other countries, particularly in the tropics, suffer and die needlessly from lack of funds and manpower to provide immunization, WHO said.

The Voluntary Fund, based here and created in 1960, is used for activities beyond WHO's regular budget of \$115,000,000 for 1975.

Agreeing that inadequate screening programs may be more trouble than they are worth, Dr. David Satcher of the King-Drew Medical Center in Los Angeles complained that screening for sickle cell trait is pointless if it cannot be followed up by competent genetic counseling.

Legal and Job Problems Cited

"There are just not enough physicians and adequately trained health professionals to do the kind of genetic counseling we have been saddled with since the mass screening programs were initiated," he said, noting that the misunderstanding of sickle cell trait and its implications often leads to legal and employment problems for the affected individual.

"Recently in a Los Angeles County agency, a physician had been routinely turning down all applicants for a job who had the sickle cell trait and the only way we found out about it was because of the persistence of a young woman who had applied for the position and who felt she was being erroneously discriminated against," Dr. Satcher said.

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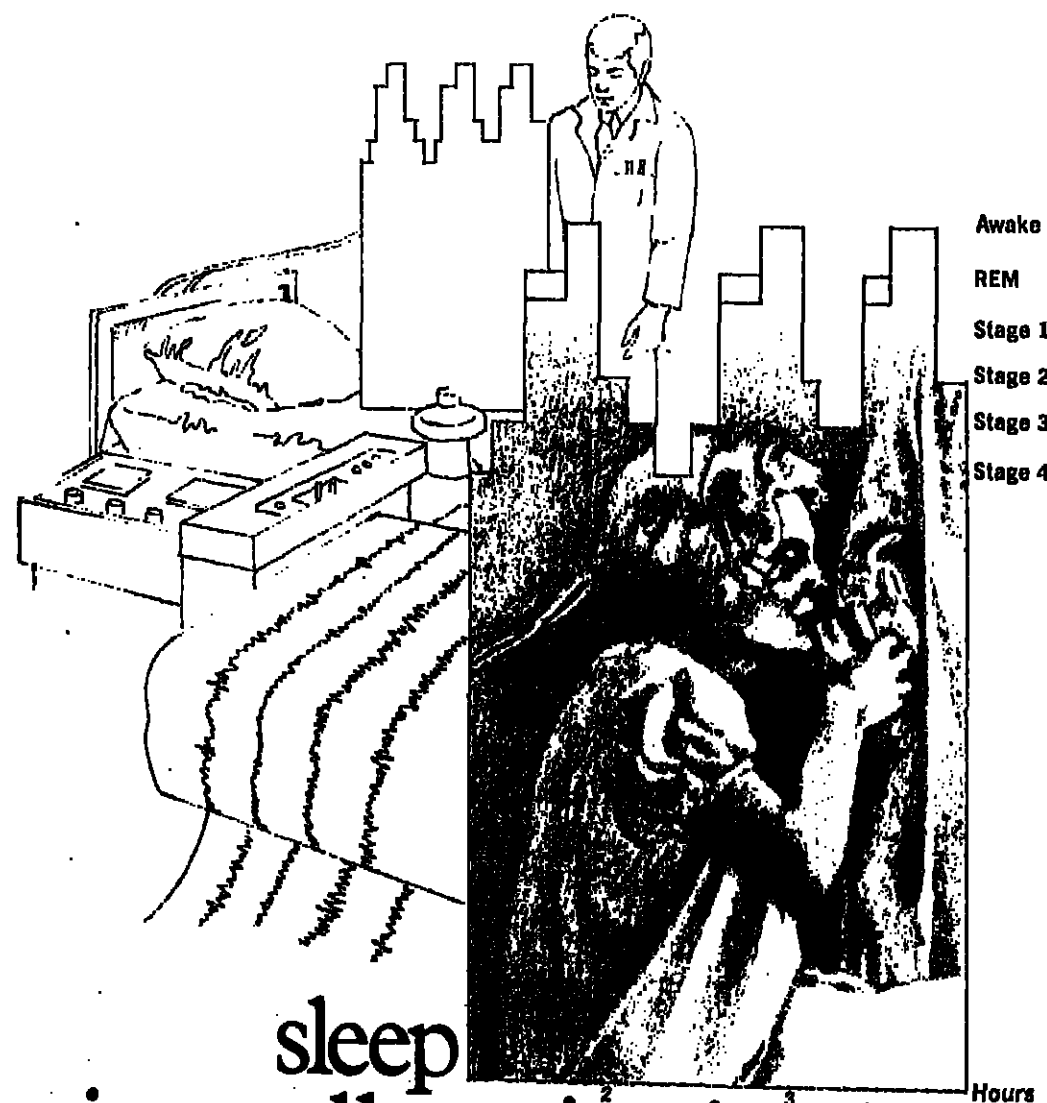
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One Man...and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune



Is There Only One True Science? RESEARCH AND PATIENTS' RIGHTS - PART II

There are those for whom issues are more important than individuals. Such may be the case at hand in regard to the present attack on XYY chromosome research.

A group of Boston "scientists" calling themselves "Science for the People", among whom physicians and clinicians are noteworthy by their absence, have charged that studies of children with extra sex chromosomes are unethical, unscientific, and potentially harmful to the children, that they can cause parental anxiety and other problems. It has been pointed out that the XYY chromosomal pattern has been reported to occur in higher frequency in mental and penal institutions and that a notorious murderer was incorrectly reported as having the XYY karotype. Thus, those very "scientists" who raise the question of the "unfair identification" of individuals with different chromosomal make-up are perpetuating the very conditions which they say "jeopardize" those they claim to protect by recirculating inaccurate reports and by suggesting that nothing can be done for individuals with different chromosomal patterns. Let us examine the ultimate implications of their position.

Folly of Stopping Tests

Let's assume that a simple urine test done shortly after birth could prognosticate future schizophrenia or malignancy. Should such a test be stopped on the grounds that we do not have good enough therapies for either the schizophrenias or the malignancies—therapies that would satisfy such groups as "Science for the People"? Should such tests be interdicted by law because they would cause parental anxiety and concern? Or, should such tests be done without informing the family, thus violating "full disclosure" and "informed consent"? Or should press freedom be suspended to "protect the people" from either misinformation or anxiety?

And what about terminal malignancy? Will "Science for the People" sue on the basis of their "logic" to prevent physicians from informing patients on the grounds that the presence of an incurable disease should interdict the physician's "creating" patient anxiety? Can "Science for the People" create by legislation more sensitive procedures than our present practice of the physician's selectively deciding what a patient can or cannot "tolerate" in respect to life and death?

Mocking "Full Disclosure"

And what about "Full Disclosure"? Is that right now to be restricted only to conditions for which they are remedial measures? It would seem to make a mockery of the term.

What is "Informed Consent" to be? What is the significance of "Informed Consent" if participation in research procedures is first to be determined upon a class basis by law rather than

on an individual basis by choice—no right to research participation for prisoners, mental patients, now XYY children—and what next?

And what about my rights—my right to have my children participate and benefit from the fruits of new research and new knowledge? Can "Science for the People" preempt my rights; can they as a group take precedence over my rights as an individual to participate in a research cohort?

The Cloaked Attack

Is not "Science for the People" a misnomer or a cloak which hides another intent? I have noted increasing attacks on biologic science by those who believe that social, economic, and environmental factors are the primary or sole determinants of disease and social deviancy. The extremity of such claims for social and environmental etiologies should be examined.

Perhaps it is pertinent to point out that no group, certainly no publication, has matched Medical Tribune as it fought against environmental pollution before the word "ecology" became common; its campaigns for auto safety well before Nader became known; its attacks on addiction to alcohol and cigarettes as two of the commonest preventable causes of disease and death; and its support of all measures to improve nutrition and housing as essential substrates for good health.

True "Science for the People"

If we are to have a true "Science for the People," then we need both better social conditions and more and better science—not one in place of the other. To pit social needs versus science is a disservice to both; it is a disservice to "people" as well as science. To expose scientists once again to vicious attacks based on dogma is to have us borne back to the "Dark Ages" before the "Age of Enlightenment" by a new breed of Inquisitors—neither Grand, nor church appointed, but immodestly self-appointed. Responsible individuals, organizations and organs of science must promptly address the growing number of attacks on its members and its methods, lest both be subverted by an "anti-science" cloaking itself in the mantle of the "only true" science, claiming for itself the only "legitimate" expression of science, "Science for the People."

We cannot say it often enough—*"Anti-intellectual means cannot be justified by proclaimed social ends."*

TV Facilitates Heart Disease Diagnosis



A new adult cardiac study unit has opened at the University of Michigan Hospital. Here, doctors are seen reviewing a video tape showing injection of a contrast medium into a patient's heart. This form of "instant replay" allows cardiologists to know immediately if the x-ray study has been effective or will have to be repeated.

Tobacco, Marijuana Smoke Inhibit Macrophage Action

Medical Tribune Report

NEW ORLEANS—Animal experiments with pulmonary alveolar macrophages suggest that, in terms of susceptibility to bacterial infection, marijuana smokers—an estimated 25,000,000 of them in the United States—would do well to use a water pipe.

Dr. Gary L. Huber, Assistant Professor of Medicine at Harvard Medical School, reported to the 40th Annual Scientific Assembly of the American College of Chest Physicians here on experiments at Beth Israel Hospital, Boston, with such macrophages taken from rats by bronchopulmonary lavage.

The macrophages were mixed with bacterial suspensions of *Staphylococcus albus* and humidified smoke from the National Institutes of Health reference marijuana units, from tetrahydrocannabinol-extracted marijuana placebo cigarettes, and from reference Kentucky tobacco cigarettes, and viable bacteria were subsequently counted.

Bactericidal Activity Depressed

Control macrophages not exposed to any smoke reduced the number of living bacteria to 26 per cent within three hours of incubation. But both tobacco smoke and marijuana smoke depressed essentially all bactericidal activity of the test macrophages: 83.3 per cent of the Staph remained viable over the same three-hour interval when the mixture was exposed to tobacco smoke, and a similar proportion survived in the marijuana condition.

Dr. Huber's team also investigated the effects of stale versus fresh marijuana and tobacco smoke in the same system.

"Whatever the potential cytotoxic ingredient present, it was found only in fresh smoke," Dr. Huber stated. "Delay of delivery of the smoke to the tissue culture flask removed or altered macrophage cytotoxicity."

Again, no discernible difference between tobacco and marijuana smoke could be established, he noted.

Use of an absolute filter disk to re-

move all particulate matter from the marijuana smoke, producing a pure filtered gas phase of the smoke product, did not change the results.

"The gas phase depressed macrophage activity in a manner comparable to whole smoke," Dr. Huber reported.

But "filtration of this gas phase component through water removed the macrophage cytotoxicity, resulting in no impairment in macrophage activity," he said.

Further studies strongly suggested that tetrahydrocannabinol, the principle psychoactive component of marijuana, is not the cytotoxin in question, Dr. Huber said. Eight ml. of whole marijuana smoke impaired macrophage function is essentially the same degree as 8 ml. of smoke from THC-extracted marijuana placebo, and the further addition of a proportionate amount of purified THC had no effect on alveolar macrophage function.

Other members of the research team were Mary Beth Cutting, S. Goodenough, A. Watson, G. Simmons, and Dr. Raul Laguarda.



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EDITORIAL CAPSULES

... brief summaries of editorials or comments in current medical and scientific journals.

Exercise and the Heart

"None of the . . . data prove that exercise training can alter the development of ischemic heart disease or help patients with established coronary artery disease. However, recent reports on the use of exercise in diminishing the incidence and severity of angina pectoris have been promising. The mechanism of response of angina to exercise training might involve reductions in the reactions of the heart rate and the arterial pressure to exercise, possibly enhanced myocardial oxygen delivery, and a decreased cardiac output for a given amount of exercise . . .

"Exercise training can improve the claudication distance in patients with peripheral vascular disease. If it be accepted that the pain of intermittent claudication is similar in its pathogenesis to that of angina pectoris, then the effects of exercise on intermittent claudication also argue for exercise training in patients with angina pectoris. Exercise training in man is accompanied by metabolic alterations in peripheral muscle; there are increments in the size and oxygen uptake of peripheral muscle mitochondria as well as in the overall tissue contents of glycogen, glycogen synthetase, and hexokinase. . . .

"Exercise programs have also been used to help rehabilitate patients after myocardial infarction . . . Exercise is not without dangers and the physician advising exercise as either a therapeutic or diagnostic procedure has definite medicolegal responsibilities. The presence of emergency defibrillation equipment during training sessions is held to be essential by some workers. . . ." (Editorial, Lionel H. Ople, M.D., *Amer. Heart J.* 88:539, Nov. 1974)

Drugs and Diets

" . . . If a fraction of the attention devoted to assessing new drugs was turned on to diets, it could reap handsome rewards for the science of therapeutics. . . . Too many attempts to investigate dietary treatment have been so poorly controlled that the results would not have been published if they had referred to drugs. Moreover, investigations of the contribution of diet to disease have a potentially important preventive role. Burkitt, Cleave, and others have stimulated thought about diseases which may have been caused by one form of dietary deficiency—lack of fibre, and its replacement by refined carbohydrate. Their postulates now need exact evaluation, and many doctors are properly concerned about the obesity epidemic which is spreading from the U.S.A. to Great Britain, let alone the complicated questions about diet in prevention and treatment of degenerative arterial disease. Perhaps a subsection of clinical pharmacology devoted to diet and disease needs to be founded. Just as with drugs, for dietary prescription the best guide is do no harm." (Editorial, *The Lancet* 2:994, Oct. 26, 1974)

Home Culturing of Urines Helpful in Children

Medical Tribune Report

SAN FRANCISCO—Home culturing, using the roll-tube technique, has proved to be an economic and efficient method of checking the urines of children with recurrent bacteriuria for the presence of infection.

Dr. Robert Fennell, of the Shands Teaching Hospital, Gainesville, Fla., said that parents can be taught to obtain clean-catch midstream urine, as well as bladder and ileal-conduit specimens by catheterization if necessary; to culture the urine at home; and to count the number of colonies in the culture.

At his institution, 350 patients with a history of recurrent infections have been participating in such a program, he reported. Cultures are done weekly

following an infection and monthly if a patient has been infection-free for eight weeks. Home culturing is supplemented by clinic visits every two to three months.

2nd Home Culture If Positive

When a home culture is positive, a second culture is done before a clinic culture. Clinic cultures have been positive for the same organism found in two positive home cultures 65 per cent of the time, Dr. Fennell said, and 5 per cent of cultures negative at home have been positive in the clinic.

The home screening appears to have detected a "significant number" of infections that otherwise might have gone undetected, he commented. The

method can be substituted for prophylactic antibiotics, while the physician maintains control of the situation, he added.

Parental involvement is a significant factor in the success of such a program, Dr. Fennell went on. Both the patient and the parents assume a sense of control and responsibility for the disease, realizing that urine infections can lead to chronic pyelonephritis and severe kidney disease, he said.

The home culture program was the subject of a scientific exhibit at the American Academy of Pediatrics meeting here. Drs. R. D. Walker, E. H. Garin, and G. A. Richard, and Sandra Austin collaborated on the exhibit report.

situation: constipation: laxation:

Post-operative . . . recent surgery . . . still confined to bed . . . or restricted ambulation . . .

Constipating analgesics and sedatives . . . Immobilization . . . reduced food and fluid intake . . . constipation common . . . fecal impaction a threat to be avoided . . .

Gentle and predictable with colon-specific SENOKOT Tablets/Granules. Virtually free from side effects in appropriate dosage.

Supplied: SENOKOT Tablets (small, easy-to-swallow)—Bottles of 50 and 100. SENOKOT Granules (delicious, cocoa-flavored)—4, 8 and 16 ounce (1 lb.) canisters.

Senokot

(standardized senna concentrate)
Tablets/Granules

a natural laxative

Purdue Frederick

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Vitamin Extends Fibroblasts' Life In Tissue Culture

Medical Tribune Report

SAN DIEGO, CALIF.—New evidence that vitamin E can almost double the life span of human fibroblasts in tissue culture was presented at the 14th Annual Meeting of the American Society for Cell Biology in Cell Biology.

When the fibroblasts were grown in the presence of from 10 to 100 micrograms of vitamin E (tocopherol) per ml. of medium, the cell populations divided about 100 times. That compares with the approximately 50 cell divisions normally expected before the same kind of cells stop multiplying, according to Dr. Lester Packer, University of California, Berkeley, and Dr. James R. Smith, Veterans Administration Hospital, Martinez, Calif.

"In tocopherol-treated cells at the 97th passage level, about 95 per cent of the cells are capable of synthesizing DNA, which suggests that their cells are capable of many more population doublings. Furthermore, growth of cultures for 30 population doublings in the presence of tocopherol also confers at least 30 additional population doublings to their in vitro life span," they said.

In addition, they said, the older cell populations treated with vitamin E were morphologically similar to the younger cells from which they descended.

Effect on Oxidation Damage

It is possible, although not yet proven, that the tocopherol may have in some way interfered with the build-up of oxidation products, as appears to happen in aging cells, Dr. Packer suggested in an interview. When he and Dr. Smith exposed fibroblasts to the environmental stresses that would produce such oxidation damage, including visible light and high oxygen levels, they found that tocopherol seemed to "slow the occurrence and accumulation of oxidative damage such that the growth potential and survival of human fibroblasts in vitro is enhanced."

Asked whether or not the Berkeley experiments provide support to those who claim that large doses of vitamin E increase human lifespan, Dr. Packer refused to speculate.

"There is a different mechanism of aging at every level of biological organization, and aging in one type of cell in tissue culture cannot be equated with the aging process in humans," he said.

In a companion paper, Dr. Alexander Sun, also of the University of California at Berkeley, reported that there was a sharp increase in the concentration of three different enzymes as human cells aged in tissue culture. He found that the activity of cytochrome oxidase increased 300 per cent in aging cells, N-acetyl-glucosaminidase doubled, and 5-nucleotidase increased by as much as 100 per cent.

"The striking increases in 5-nucleotidase may be related to ATP metabolism and to other work in this laboratory (Packer's work) showing that vitamin E reduces the accumulation of oxidative damage and markedly extends cell life span," Dr. Sun said. Co-author was B. B. Aggarwal.

Esimil...begins with a thiazide

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg



Esimil

guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg

INDICATIONS
Hypertension. (See box warning.)

WARNING
This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

CONTRAINDICATIONS
Guanethidine known or suspected pheochromocytoma; hypersensitivity; frank congestive heart failure not due to hypertension; use of MAO inhibitors.
Hydrochlorothiazide: Anuria; hypersensitivity to this or other sulfonamide-derived drugs. The routine use of diuretics in an otherwise healthy pregnant woman with or without mild edema is contraindicated and possibly hazardous.
WARNINGS
Antihypertensives are potent drugs and can lead to disturbing and serious clinical problems. Physicians should be familiar with all drugs and their combinations before prescribing, and patients should be warned not to deviate from instructions.

Guanethidine

Warn patients about the potential hazard of orthostatic hypotension, which can occur frequently and is most marked in the morning or after meals. To help prevent fainting, warn patients to get up slowly, especially if they are on a low-salt diet. The potential occurrence of these symptoms may require alteration of previous daily prolonged standing or exercise while taking the drug.

Concurrent use with rauwolfia derivatives may cause excessive postural hypotension, bradycardia, and mental depression.
If possible, withdraw therapy 2 weeks prior to surgery to reduce the possibility of vascular emergency surgery is indicated, administer pre-anesthetic and anesthetic agents cautiously in vasoconstrictor and have oxygen, atropine, and IV solutions ready for intravenous use to treat vascular collapse. Vasopressors should be used with extreme caution in patients on guanethidine because of the possibility of augmented response and the greater propensity for cardiac arrhythmias.

Dosage requirements may be reduced in presence of fever. Exercise special care when treating patients with a history of bronchial asthma, since their condition may be aggravated.
Use with caution in severe renal disease. In chronic renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.
Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid

and electrolyte imbalance may precipitate hepatic coma.
Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potential occurs with ganglionic or peripheral adrenergic blocking drugs.
Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.
Use in Pregnancy
Guanethidine: The safety of guanethidine for use in pregnancy has not been established; therefore, this drug should be used in pregnant patients only when, in the judgment of the physician, its use is deemed essential to the welfare of the patient.
Hydrochlorothiazide: Use of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers
Thiazides cross the placental barrier and appear in cord blood and breast milk.

PRECAUTIONS
Guanethidine: The effects of guanethidine are cumulative over long periods; initial dose should be small and increased gradually in small increments. Use very cautiously in hypertensives with renal disease and nitrogen retention or renal insufficiency or recent myocardial infarction; cerebral vascular disease, especially with encephalopathy. Do not give guanethidine to patients with severe cardiac failure except with extreme caution.
In impenitent cardiac decompensation weight gain or edema may be caused by the administration of a thiazide. Remember that both digitalis and guanethidine slow the heart rate.

...because it is the standard initial therapy—the logical foundation upon which to build. And we picked hydrochlorothiazide, the most widely prescribed diuretic-antihypertensive, which we

...added to perhaps the most effective antihypertensive available, guanethidine...

to create a logical team of therapeutic activities
...for controlling moderate to severe hypertension.

to provide an alternative therapy
...which often controls hypertension in patients not responding to sedatives, diuretics, rauwolfia-thiazides, or other centrally acting inhibitors alone or in combination.

to avoid exacerbating the problem of mental depression
...because Esimil contains no reserpine.

to encourage patient compliance
...because Esimil usually works in once-a-day dosage.

Like all antihypertensives, Esimil should be given with caution in the presence of severe coronary insufficiency or recent myocardial infarction.

Dissatisfied with your present antihypertensive therapy? Why don't you start with the same effective components we did, and when your carefully titrated dosage matches ours—switch to Esimil.

titrate to
Esimil
guanethidine monosulfate 10 mg
hydrochlorothiazide 25 mg

Peptic ulcers or other chronic disorders may be aggravated by a relative increase in parasympathetic tone.
Amphetamine-like compounds, stimulants (eg, ephedrine, methamphetamine), tricyclic antidepressants (eg, amitriptyline, imipramine, desipramine) and other psychopharmacologic agents (eg, phenothiazines and related compounds), and oral contraceptives may reduce the hypotensive effect of guanethidine. Discontinue MAO inhibitors for at least one week before starting guanethidine.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hypotension, hypochloremic alkalosis, and hypokalemia). Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence electrolyte balance. Watch for signs of dehydration, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbance such as nausea or vomiting.

Hypokalemia may develop with thiazides as with any other potent diuretic, especially during brisk diuresis, when severe cirrhosis is present, or during concomitant administration of steroids or ACTH.
Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity.
Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Distal renal tubular acidosis may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances when the hyponatremia is life-threatening.

In actual salt depletion, appropriate replacement is the therapy of choice.
Transient elevations in plasma calcium may occur in patients receiving thiazides, particularly in those with hyperparathyroidism. Pathological changes in the parathyroid gland have been reported in a few patients on prolonged thiazide therapy.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness to succinylcholine. The antihypertensive effects of the drug may be enhanced in the post-sympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If nitrogen retention indicates onset of progressive renal impairment, consider withholding or discontinuing diuretic therapy.

ADVERSE REACTIONS
Guanethidine: Frequent reactions due to sympathetic blockade—dizziness, weakness, lassitude, syncope. Frequent reactions due to unopposed parasympathetic activity—bradycardia, increase in bowel movements, diarrhea (may be severe and necessitate discontinuance of the drug). Other common reactions—inhibition of ejaculation, fluid retention, edema, congestive heart failure. Other less common reactions—dyspnea, fatigue, nausea, vomiting, nocturia, urinary incontinence, dermatitis, scalp hair loss, dry mouth, rise in BUN, pitting of the face, blurring of vision, parotid tenderness, myalgia, muscle tremor, mental depression, chest pains (angina), chest parasthesias, nasal congestion, weight gain, and asthma in susceptible individuals. Although a causal relationship has not been established, a few instances of anemia, thrombocytopenia and leukopenia have been reported.

Hydrochlorothiazide: Gastrointestinal—anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic), pancreatitis. Central Nervous System—dizziness, vertigo, parasthesias, headache, xanthopsia. Dermatologic—Hypersensitivity—purpura, photosensitivity, rash, urticaria, necrotizing angitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. Hematologic—leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. Cardiovascular—orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Other—hyperuricemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, reduce dosage or withdraw therapy.

DOSEAGE
As determined by individual titration (see box warning).
Note: 10 mg guanethidine monosulfate present in Esimil is equivalent to 8.4 mg guanethidine sulfate USP.
Before starting therapy, consult complete product literature.
HOW SUPPLIED
Tablets (white, scored), each containing 10 mg guanethidine monosulfate and 25 mg hydrochlorothiazide; bottles of 100.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C I B A

Tribune Economic Analysis



With costs continuing to spiral, the airlines' only hope of rebuilding traffic is to offer bargains in fares. The only route to fare-cutting is by cutting back on services. This raises the fear that the services most likely to be cut will be maintenance and repair. But the only change coming in airline maintenance budgets is on the up side. Looking for places to cut goes back to defining what business the airlines are in and what they are not in. Affluence encouraged the airlines to use the psychology of getting something for nothing. It also caused them to confuse the air-shuttle game with some kind of flying substitute for posh restaurants. The airlines could effect really meaningful savings if they could get rid of their catering burden on all but their longest flights. Even relief from the cost of printing their chichi menus would help.

Cutting back on the bar and restaurant, and offering a cash saving to passengers would make a difference. Suppose, when all the smoke cleared away, paring down food services netted an average saving of \$15 a ticket. And suppose the airlines split it with their passengers. This would give them better advertising than all the efforts they could make in posh dining.

Another experiment they might try is telling passengers about the high cost of handling baggage. Offering an incentive discount to passengers who use the space in the cabin instead of in the hold would yield a dollar to split both ways, too.

Despite today's high mortgage interest rates, is this the time to invest in income real estate, specifically the new garden apartment projects that have not been rented yet?

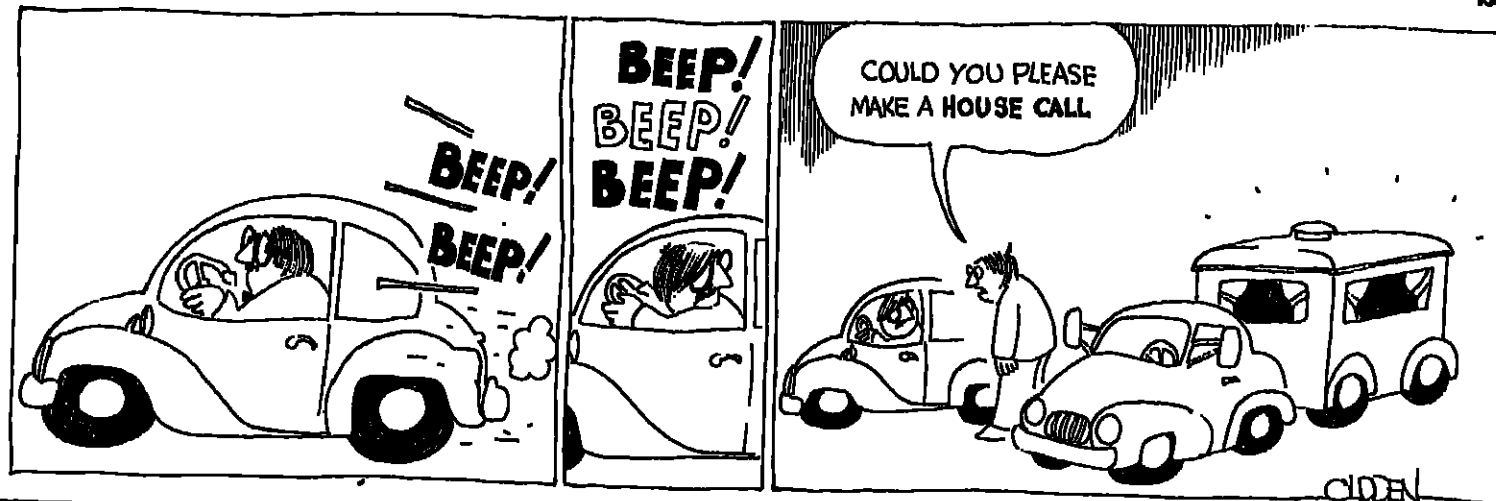
Dr. E.J., St. Louis

There are worse things you might do with good money, but I cannot think of them. New investment in income property today buys the worst of both worlds—costs too high to be absorbed by the present level of rents, and rents too low to absorb the present level of costs. Potential tenants are running out of rent-paying power faster than landlords are running out of tenants.

Will the government antitrust suit at AT&T force its stock down? What will happen if the government wins? Oklahoma Physician

It already has. A disaster that will make the present state of affairs and present interest rates seem to hindsight like tranquil times. Providentially, however, I don't see any chance that the government can win, and I do see considerable chance that it will recognize its blunder and save face before its suit does any more damage to our battered markets.

Clinical Trials



by Olden

TRIBUNE SPORTS REPORT

Middle-Aged Joggers Show Healthy Lipoprotein Pattern

Medical Tribune Report

DALLAS—The vigorous middle-aged male jogger achieves and maintains a lipoprotein pattern that not only is distinctively different from that of his sedentary peer, but also "might be mistaken for that of a typical younger woman," the American Heart Association was told here.

In fact, the fasting plasma lipoprotein distribution in such men is one that is "considered by most authorities to be conducive to heart health," according to Dr. Peter D. Wood, Adjunct Professor of Medicine and deputy director of Stanford's Heart Disease Prevention Program.

In detailing what is believed to be one of the first studies to measure plasma total cholesterol and triglycerides in long-distance male runners and in randomized controls, Dr. Wood said the joggers, aged 35 to 59, had significantly lower plasma low-density-lipoprotein (LDL) and significantly higher high-density-lipoprotein (HDL) cholesterol levels than the controls. The HDL/LDL ratio was higher in runners, total cholesterol was "modestly lower," and plasma triglycerides were "strikingly lower" in the active group.

15-Mile-a-Week Joggers

The findings were made in a study of men in northern California who had jogged an average of at least 15 miles a week for the preceding year. Dr. Wood stressed that most were not life-long athletes, and "a number of them reported taking up running in their late 30s or 40s at a time when they were unfit, overweight, and cigarette smokers." At the time of the study, all had stopped smoking and were reasonably lean, with a mean body fat content of 13 per cent.

The controls consisted of 743 randomly selected men, aged 35-59, who were measured for fasting plasma total cholesterol and triglycerides, and a subgroup of 137 men who were also measured for plasma HDL and LDL cholesterol levels. Dr. Wood noted that the controls were predominantly men of relatively sedentary habits.

All blood samples were drawn in the morning, following a fast of 12-16 hours. The runners were asked not to do any vigorous exercise during the fasting period, so that the values shown were not immediately after exercise.

For every age group in the study, triglycerides levels were "much lower" for the runners, Dr. Wood reported. For the total group, the runners "had less than half the mean triglyceride concentration of the controls (70 versus 146 mg. per cent)."

Plasma HDL concentration in the joggers showed a mean of 65 mg./100 ml., compared with 43 mg./100 ml. for controls, and plasma LDL cholesterol levels in the active group were a mean of 125 mg./100 ml., compared



with 139 mg./100 ml. in controls. The HDL/LDL cholesterol ratio in plasma was thus "considerably higher" in the runners, with values at .52 compared with .31 for controls.

"We conclude that our middle-aged runners have plasma lipoprotein patterns that are quite different from those of average, generally sedentary men of the same age from nearby communities," Dr. Wood commented. "In fact, the runners' patterns, with a low VLDL (very-low-density lipoprotein) level, a high HDL level, and relatively low LDL level, might be mistaken for that of a typical younger woman."

Adiposity Not Important

He emphasized that regression and correlation studies, in both the joggers and the control group suggested that adiposity "is not a very important variable in seeking an explanation for the pronounced lipoprotein differences between runners and controls. Although our study does not establish it, we feel it most likely that the greatly increased exercise level of the runners is by itself the major factor responsible for the advantageous plasma lipoprotein pattern observed in this small but rapidly growing group of very active middle-aged men."

Coauthors were: Herbert Klein, Steven Lewis, and William L. Haskell, Ph.D.

Lung Association Unveils New TB Classifications

Medical Tribune Report

NEW YORK—The American Lung Association has released new classifications for tuberculosis.

"Twenty years experience with anti-TB drugs proves that adequate chemotherapy can cure, rather than just arrest, TB," said Dr. John G. Weg, Professor of Internal Medicine at the University of Michigan. "Because TB no longer is a disease with a lifetime of flareups and remissions, the patient can be discharged from care, with TB records becoming a part of the medical history, just like any other condition from which he or she has recovered."

Dr. Weg chaired a committee of the American Thoracic Society which prepared the new edition of *Diagnostic Standards and Classifications of Tuberculosis*, the standard reference on TB, in which the new classifications appear.

The new classifications are:

- No tuberculosis exposure, not infected. No history of exposure, negative tuberculin skin test.
- Tuberculosis exposure, no evidence of infection. History of exposure, negative tuberculin test.
- Tuberculosis infection, without disease. Positive tuberculin skin test, negative bacteriological studies (if done), no X-ray findings compatible with tuberculosis, no symptoms due to tuberculosis.
- Tuberculosis: infected, with disease. The current status of the patient's tuberculosis is described by three characteristics: location of the disease, bacteriological status, and chemotherapy status. For some patients additional characteristics—X-ray findings and tuberculin skin test reaction—would be included.

Alan Guttmacher Institute

Medical Tribune Report

NEW YORK—The Planned Parenthood Federation of America has formed the Alan Guttmacher Institute to serve as its research and development division. Dr. Guttmacher, who died last April, had been federation president for more than 10 years. The institute's national council will be headed by Dr. Philip R. Lee, former Assistant Secretary for Health and Scientific Affairs.

IMMATERIA MEDICA

By DUDLEY STRAUS

More Odds, More Ends

• In case you want to know what they're reading in college these days, the literature seems to include *Hulk*, *Spider-Man*, *Werewolf by Night*, *Iron Man*, and *Man-Thing*.

We've picked up this bibliographic information from an order form that, for reasons unknown, landed on our desk, hot from Marvel Comics. The form lists 36 of these gems of literature and art, and bills them as the "College Student Comic Line." Anyone who places an order is supposed to let old Marvel know if he's an undergraduate or a graduate student.

• A Reuters dispatch in the *Washington Post* reports an Australian solution to one of the problems of the Age of Communication:

"CANBERRA.—A government organization has found a new use for its reports—feeding them to sheep.

"Research scientist Dr. Barry Coombe, of the Commonwealth scientific and industrial research organization, has been using old printed reports as part of an experimental diet for sheep, and the latest bulletin says they are thriving."

• The zippiest lead sentence we've seen in many a day began a release from the University of Minnesota:

"Excuse me a second doctor, got some business," the girl said, running off the end of a pop bottle. Then she joined another patient who was engaged in a fight with a member of the hospital staff."

• An amazing number of publicity releases touting new examples of good-old-American-know-how cross our desk. For once, we've been taken aback by a notice pushing a "new invention" that may be less absurd than most.

Its name is *Backbrief*, and it's a padded tapered attaché case that you stick behind your back while driving, flying, or sinking into the family sofa. It's said to be no good for the very obese who need the whole seat for themselves.

• "A U.S. certified, registered, licensed midwife [who] has delivered over 3,500 bundles of joy," and who is named Norman Casserley, has petitioned a Houston, Tex., court to change his name to Mister Midwife, we are informed by a news release from the International Association for the Advancement of Lay Non-medical Midwives. Will his nephews call him Uncle Mister, we wonder.

• If necessary, eat this item to prevent it from reaching your children, for, according to United Press International, a Dr. Rudolf Link, of the Hamburg (West Germany) Ear, Nose, and Throat Clinic, states that children who refuse to wash their ears may be right: "Ear wax is not dirt. It protects the drum of the ear. There is no place for soap and water in these sensitive organs," he says.

Psychosomatic Illness Seen Getting Psychiatric Spotlight

Medical Tribune World Service

ST. URBAN, SWITZERLAND—Psychosomatic illnesses, neurosis, and drug addiction will be the major preoccupations for psychiatrists 10 years from now, according to an opinion survey in Germany, Austria and Switzerland.

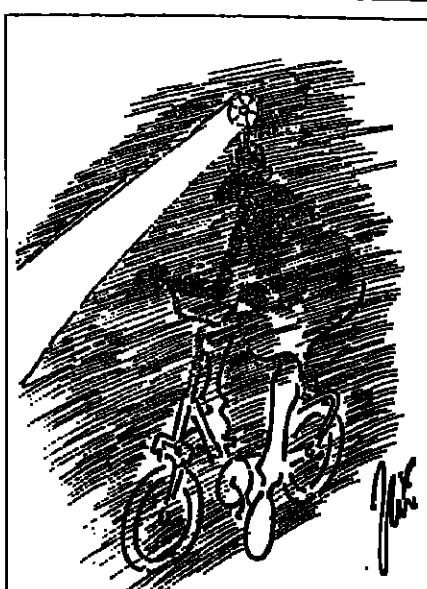
Asked which scientific discipline is most likely to assist in the progress of psychiatry, many respondents (46 per cent) said biochemistry. Next was pharmacology (24 per cent), then sociology (14 per cent), but only 11 per cent replied depth psychology.

The poll, described at the annual meeting of the Swiss Association of Psychiatrists at the St. Urban psychiatric Clinic, near Bern, by Dr. Walter

Poeldinger, found pharmacotherapy regarded as the major therapeutic trend of the future, with a vote of 58 per cent. Social therapy scored 24 per cent and psychotherapy only 9 per cent.

Dr. Poeldinger said that those questioned included 234 psychiatrists, 111 physicians not practicing psychiatry, and 78 non-MDs. The last consisted of 21 psychologists, 21 research scientists, and 36 sociologists and social workers.

Asked about organizational structure, the majority of psychiatrists replied that by 1985 the big, centralized psychiatric hospital will have been replaced by psychiatric wards attached to general hospitals.



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from tension headache*

Let Fiorinal help release the patient from the aching. Its analgesic components help relieve pain while its pressing, painfully tight feeling of tension headache. Sedative component helps relax the patient.

ANALGESIC plus SEDATIVE
Fiorinal®

Each tablet or capsule contains: Sandoptal® (butalbital) (Warning: May be habit forming) 50 mg.; caffeine, U.S.P., 40 mg.; aspirin, U.S.P., 200 mg.; phenacetin, U.S.P., 130 mg.

*Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: For use to relieve pain, in "conditions in which combined sedative and analgesic action is desired, such as, nervous tension and sleeplessness associated with pain or headache." Final classification of the less-than-effective indications requires further investigation.

Contraindications: Hypersensitivity to any of the components. Precautions: Due to presence of a barbiturate, may be habit forming. Excessive or prolonged use should be avoided. Side Effects: In rare instances, drowsiness, nausea, constipation, dizziness, and skin rash may occur. Adult Dosage: One to two tablets or capsules, repeated if necessary up to 6 per day, or as directed by physician. Before prescribing, see package insert for full product information.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07924